VOLUME 3:

Service Delivery System

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NARBHA recognizes the importance of behavioral health (members) having the ability to make choices about their providers, as well as choices regarding their treatment. NARBHA educates members about their right to choose, as well as assisting them with choosing providers and treatment options that meet their needs in a culturally sensitive manner. The primary methods of informing members about their right to choose providers and specific services through the enrollment process when providers make members aware of their options and provide the NARBHA Member Handbook, which includes descriptions about member choice. Information regarding members' rights to choose providers and services are available through other communication vehicles, such as NARBHA Member Service Representatives and the NARBHA website.

Choice of Provider

Geographic convenience is an important factor in a member's choice of providers. NARBHA has structured its provider network to assure access to geographically convenient services by organizing its large and often remote area into nine sub-regions, and then contracting with community-based, comprehensive behavioral health service providers, the Service Area Agency or Tribal Area Agency (SAA/TAA), for each sub-region. The SAA/TAA structure permits members a choice of behavioral health professionals who are employed or contracted by the SAA/TAA that is responsible for the sub-region where the member resides. Members residing in the NARBHA area may contact their local SAA/TAA provider directly for services, or are referred to that organization by contacting the NARBHA Member Service Representatives. During enrollment, members are able to make choices regarding the professionals who will be involved in planning and delivering services, and are matched to staff based on staff availability, language, gender, and specialized needs.

Members are educated about their rights related to choice of provider through the member handbook, which is made available at the time of enrollment, and the NARBHA website which is available prior to and at any time during treatment. SAAs/TAAs are required to distribute the Member Handbook and also advise members of their right to choose providers.

If members wish to receive services at an alternate SAA/TAA, due to another agency being closer, their desire for a different provider, or a conflict of interest situation with their home provider, members can file a Cross-service Area Request in writing with NARBHA. This request is submitted to the Quality Management Department, where it is researched and evaluated; and then approved by the NARBHA Chief Executive Officer (CEO). Client choice is a major determining factor for approval of these requests. During the last fiscal year, NARBHA approved all but two Cross-service Area Requests. Two requests were denied because granting the request would have affected the ability to develop Child and Family Teams that incorporated services provided in the community where the child and family reside.

Members also may request a specialized evaluation, or specific service, or request a second opinion from an SAA/TAA other than their home provider agency. These requests are also forwarded to NARBHA for review. The NARBHA CEO either approves a limited amount of services or denies the request. The request may be for a specific service which may not be available in the local area. The requests are researched and generally approved based upon client choice. If a member requests services from a provider who is not part of NARBHA's contracted provider network, the request is submitted to the SAA/TAA, and if approved, single case agreements can be entered into to facilitate services from the identified provider. During the past year, NARBHA had approximately 90 single case agreements in place, primarily for the purpose of facilitating member choice and meeting specialized needs.

Native Americans residing on the Navajo Reservation may choose whether to receive services through the Navajo ADHS/DBHS Tribal contractor on the reservation or a RBHA from any part of the state. Native Americans on other reservations have the choice of receiving services from an eligible Medicaid provider on the reservation, which is outside the RBHA system, or a RBHA from any part of the state. NARBHA also contracts with two Tribal Area Agencies, which are owned and operated by their respective Tribes, as a means of ensuring that Native Americans residing on those reservations who wish to receive services from NARBHA have a choice of an agency with behavioral health professionals who are both geographically convenient and familiar with the unique needs of Native Americans residing on a reservation.

Member Choice of Services

Members also have a number of choices related to their care. They have the choice regarding the composition of their treatment team, a choice of their services through the individual treatment planning process, choices regarding family

involvement, and choices regarding culturally appropriate services available to meet their needs. Members and families are educated about their choices by either Clinical Liaisons or Family Involvement Specialists throughout the team process. Members also can choose to decline any service unless it is part of a court-ordered treatment plan.

Members are also given the choice regarding whether to receive medical services via telemedicine or face-to-face. NARBHA's extensive telemedicine network extends medical services more broadly across its large geographic region, and often allows members to receive services more quickly or in locations closer to their home. However, if members are uncomfortable with the technology and prefer face-to-face services, arrangements will be made accordingly. NARBHA requires members to sign an informed consent form to participate in telemedicine services

Members and their representatives also have the right to express dissatisfaction and to file an appeal related to their treatment. Provider agencies are encouraged to address requests and resolve these requests in an informal manner, but members have the right to file a formal appeal regarding their treatment, choice of specific services, and for specific provider staff. NARBHA and the provider network treat these requests very seriously and attempt to respond and resolve issues, in a way that respects consumer choice.

Behavioral health recipients (members) enter the behavioral health system through one of nine Service Area Agencies or Tribal Area Agencies (SAAs/TAAs) in the NARBHA region. NARBHA requires its SAAs/TAAs to provide services within required contractual time frames for Title XIX, Title XXI and non-Title XIX members who are seriously mentally ill (SMI). This includes: response within two hours for urgent requests for services (referrals), or within 24 hours for emergency referrals, or routine appointments available within seven days of referral. Once the initial assessment has been completed, the next routine appointment must be provided within 23 days. NARBHA monitors compliance with these requirements, provides technical assistance, and requires performance improvement for contracted providers who fail to meet expectations. NARBHA also intends to mirror the FY 2005 ADHS/DBHS financial incentive performance system with its contracted provider network, as an additional means to improve performance.

Immediate Response

Immediate responses to persons in need of medically necessary covered behavioral health services occur within the time frame required by clinical need, but not later than two hours from the time of referral. Crisis services are available 24 hours a day, 7 days a week, either from the member's existing provider organization or through a contracted region-wide crisis telephone provider, ProtoCall. After-hours crisis calls for six of the nine SAAs/TAAs are covered by ProtoCall, with the remaining three agencies offering their own full-time crisis call coverage. ProtoCall has appropriately credentialed behavioral health professionals available by phone 24 hours a day, 7 days a week and can page the local SAA and link members to the closest provider via direct telephonic call transfer. SAAs/TAAs can provide services telephonically, face-to-face at the provider agency, via the telemedicine (videoconferencing) network, in hospital emergency rooms, or at other locations where members are located.

Urgent Response

Urgent responses to persons in need of medically necessary covered behavioral health services occur according to clinical need, but not later than within 24 hours. Daytime services are provided by telephone, via the telemedicine (videoconferencing) network, or in person at the provider site, or in person at another location. After hours crisis calls are responded to by NARBHA's contracted crisis telephone provider, ProtoCall, for six of the SAAs. Calls are triaged by ProtoCall, and the local SAA provider is paged for a response when warranted. The member is referred to the SAA the next business day, if an urgent response is not required. ProtoCall faxes all necessary paperwork to the SAA regarding their response. The three SAAs/TAAs who do not contract with ProtoCall provide their own after hours crisis response system.

NARBHA monitors response time for daytime crisis calls, and for after-hour crisis calls taken by ProtoCall and the three SAA/TAA crisis response systems on a monthly basis, and reports findings to ADHS/DBHS. During the past year, NARBHA achieved 100% compliance in meeting the standard for response within 24 hours.

24-Hour Response – DES Removals

NARBHA has implemented a comprehensive 24-Hour Response system for Department of Economic Security (DES) removals. Through this system, Department of Economic Security/Child Protective Services (DES/CPS) refers children who have been taken into custody and placed in out-of-home care. All children referred are seen by an SAA behavioral health provider in their placement setting within 24 hours of referral. NARBHA has a dedicated 1-800 line through ProtoCall available 24 hours a day, 7 days a week, for CPS to utilize to initiate the process. Through this service, children and their caretakers have immediate access to the behavioral health system including initiation of the assessment, interim planning, enrollment, and Child and Family Team development processes.

NARBHA monitors this system on a monthly basis through a comprehensive data base. NARBHA is able to track a number of items, including the age ranges of children referred, the location where they were seen , eligibility and enrollment status, timeliness of Child and Family Teams, average time to ADES/CPS referral from removal, average time from referral to face-to-face response, and response locations.

Since implementing this process, the following data have been captured.

- Between August 15, 2003 and June 30, 2004, 250 children were seen through the 24-hour Response process. This reflects 100% of the referrals made by CPS.
- During the first 6.5 months of 24-hour Response, prior to implementing the centralized number and tracking, data show 85 responses. In the 4.5 months following the tracking, data show 165 responses. This reflects an average monthly increase of 35%, which primarily represents improved data because CPS referrals are believed to have remained nearly constant.

Data collected between February 15, 2004, and June 30, 2004 reflect the following.

- 55% of the responses were for children ages 0-6
- 94% of the children were seen in settings other than the clinic
- The average length of time from call to the first Child and Family Team was 11 days
- Only 73% of the children were Title XIX eligible.

Results are reviewed by the NARBHA Provider Performance Committee to track response time and identify barriers, if any.

Routine Appointment within Seven Days

Appointments are required to be available within seven days of the request for routine appointments. NARBHA requires SAAs/TAAs to submit data monthly that track the number of referrals for routine appointments and the percentage of appointments that were available within seven days.

NARBHA's compliance for FY 2003-2004 was 83.9%, with performance continuing to improve toward the standard of 85%. NARBHA has made intensified improvement efforts throughout the year to improve performance, including conducting a monthly analysis of compliance for each SAA/TAA, and targeting those that are not meeting the standard with focused improvement efforts. This has included plans of correction, and on-site technical assistance at two agencies to train personnel and identify specific processes needing improvement. One provider had data collection methodology problems and staff shortages. Additional staff were hired, and NARBHA provided technical assistance on site to address data collection issues. These efforts have resulted in increased compliance for provider agencies not meeting the standard over the past year. Regular reports are monitored and closely improvement efforts will be re-initiated if a provider's performance falls below expectation.

Routine Appointments for Ongoing Services within 23 Days of Initial Assessment

Ongoing behavioral health services are provided within 23 days of the initial assessment. NARBHA monitors performance for this requirement on a quarterly basis and mirrors the ADHS/DBHS monitoring of Regional Behavioral Health Authority (RBHA) performance, which includes an analysis of data submission and validity issues, as well as analysis of the time frame in which members receive their first service after the initial assessment. During FY 2004, NARBHA's performance indicates 89% compliance for members receiving a first service within 23 days of assessment which exceeds the ADHS/DBHS standard of 85%. SAAs not meeting compliance with this standard over time are required to initiate improvement efforts.

Wait Times

NARBHA requires providers to meet ADHS/DBHS standards for routine appointment wait times, which indicate not more than a 45-minute wait for scheduled appointments. In addition, provider agencies that arrange for or provide non-emergency transportation services for members must ensure that members do not arrive more than one hour prior to their scheduled appointment, nor wait more than one hour after the conclusion of their appointment for transportation home.

NARBHA monitors wait times for each of these standards on a quarterly basis. SAAs/TAAs are required to submit wait time and transportation logs to NARBHA. The information is then analyzed to determine compliance. During FY 2003-2004, NARBHA achieved 100% compliance with wait-time standards for both scheduled routine appointments and non-emergency transportation.

Referrals for Psychotropic Medication

NARBHA requires its providers to assess need for medication and ensure that the member does not run out of medication or experience a decline in their behavioral health condition. As clinically indicated, appointments for medication are provided no later than 30 days from the referral or initial request.

Substance Abuse Prevention and Treatment (SAPT) Populations

SAPT block grant populations include pregnant substance abusers and all injection drug users. NARBHA requires its providers to provide behavioral health services to these populations as indicated by clinical need, but no later than 48 hours from referral. If services cannot be provided within that time frame, providers are required to place the person on an actively managed wait list and arrange for interim services to be provided. NARBHA monitors this requirement on a quarterly basis, and initiates performance improvement requirements for those providers that are not meeting these time

frames. NARBHA provides ongoing technical assistance with the SAAs/TAAs, which has resulted in demonstrated improvement for this standard.

NARBHA's Mission and Values Statement emphasizes ensuring that services delivered within the system are accessible, timely, and efficient. NARBHA has implemented a sound referral management process to achieve those goals. The philosophy of this referral management process is that "every door is open" and that engagement and re-engagement activities occur as appropriate.

Incoming Referrals

To make it easier for individuals to get behavioral health services, NARBHA has implemented a process by which referral sources can access the system in a number of ways. Behavioral health recipients (members), their families, and other referral sources, such as healthcare professionals, social service organizations, AHCCCS health plans, and state agency staff, may:

- contact one of NARBHA's network providers to access services
- contact NARBHA through its Member Service Representatives (MSRs) for assistance with locating services and a provider in their areas
- access services through the crisis system

Any format—telephone, mail, fax or personal contact—may be used to submit a request for services. If requests for services are posed by individuals with limited English proficiency, NARBHA, in collaboration with its provider agencies, has a process to provide language assistance services through bilingual staff who agree to provide interpreter services and are trained on "Interpreter Etiquette." Additional language assistance is provided through "A Foreign Language Service", in Mesa, Arizona, offering assistance in 255+ different languages on an as-needed basis.

NARBHA and its SAAs/TAAs accept referrals 24 hours a day, 7 days a week through either direct referral to the Service Area Agencies/Tribal Area Agencies (SAAs/TAAs) or through its crisis system. MSRs are available from 8 a.m. to 5 p.m. Monday through Friday, on a 1-800 number. The process flows for each method of accessing services are described below, along with the timeliness standards for response, and how referrals with incomplete information are managed through the process. During the last quarter of FY 2003-2004, the NARBHA system has demonstrated compliance with the accessibility measures of Referral to Emergency Services within 2 hours (100%) and Referral to First Available Appointment within 7 days (92%).

Process Flow for Referrals

Received by the NARBHA Member Service Representatives: If a potential member and/or other referral source contacts the NARBHA MSRs to request services, the MSRs determine the level of urgency associated with the request. If the referral source indicates that it is a routine or urgent request, the MSRs determine the location of the individual's residence. Once the geographic location of the residence is determined, the MSRs connect the referral source to the appropriate SAA/TAA via conference call in order to connect the member or referral source directly with the provider, facilitate further triage of the request, and schedule an assessment appointment within required timeframes. If the member or referral source indicates that the request is immediate in nature, the MSR promptly links (via live transfer) the person to the appropriate SAA/TAA crisis staff, Monday through Friday, 8am- 5pm. After hours or weekends, these calls go directly to ProtoCall, a 24-hour/7-day telephonic crisis assessment system, which is described below. The NARBHA MSRs are extensively trained on all access-to-care policies/procedures and can assist members and referral sources in determining where and how to obtain services. Their activities are routinely monitored by the Quality Management Department via measures of member satisfaction with interaction, timeliness of call response, and appropriateness of information provided.

Received by the Service Area Agency/Tribal Area Agency Providers: Potential members and/or other referral sources can contact the SAA or TAA directly. The first step in the triage process is to determine the clinical nature of the need – emergent, urgent, or routine. If a request is emergent in nature, the SAAs/TAAs provide services within a timeframe indicated by need but no later than two hours from the request. If a request for services is urgent in nature, the SAAs/TAAs provide behavioral health services within 24 hours of the request. If the request for services is routine, the SAAs/TAAs offer an assessment appointment within 7 days. All intake staff at the SAAs/TAAs are extensively trained on the referral process, the appointment standards, and timeliness of services requirements. NARBHA regularly monitors compliance with these requirements through various accessibility measures and aggregate complaint data.

Received by NARBHA's Crisis System (ProtoCall): If a potential member and/or other referral source contacts the crisis system, ProtoCall clinical staff assesses the situation, provides telephonic crisis services, and if necessary, contacts the appropriate SAA/TAA for face-to-face crisis services. Contact is made with the local agencies using various means,

depending on level of acuity, including calling local law enforcement (911), live transfer of the member or referral source to the SAA/TAA, and paging the on-call staff at the SAA/TAA to call the individual. If continuing behavioral health services are required after the crisis has been mitigated, the potential member and/or referral source is offered an assessment appointment within seven days of the request. NARBHA routinely monitors ProtoCall's compliance with standards through crisis contact logs and reports. ProtoCall consistently had over 95% compliance with all of NARBHA's standards for the timeliness and quality of telephonic crisis services during the last fiscal year.

Received with Incomplete Information: NARBHA recognizes that timeliness of access to services is the most important part of an incoming referral. Therefore, all of the SAAs/TAAs in NARBHA's provider network process referrals regardless of whether the initial referral request is missing required information. After the initial referral request has been processed, the SAAs/TAAs use engagement methods in order to obtain the rest of the necessary information. If the information is so incomplete as to make it difficult to contact the potential member, the SAAs/TAAs make every effort to obtain additional information from the referral source.

Considerations for Special Populations

Native Americans: SAAs/TAAs respond to all referrals or requests for services from Native Americans regardless of their permanent address in the NARBHA region. Native Americans living on the Navajo Reservation are also informed of their option to receive services through the Navajo ADHS/DBHS Tribal Contractor.

SAPT: To ensure that timely and appropriate services are provided to the Substance Abuse Prevention and Treatment (SAPT) population, NARBHA monitors its providers referral response performance through a variety of mechanisms, including an ADHS/DBHS-approved Utilization Management tool and reports monitored by the Provider Performance Committee.

DES/CPS Referrals Pending Removal of a Child: In response to Governor Napolitano's Action Plan for Department of Economic Security/Child Protective Services (DES/CPS) Reform, which brought recognition to the unique needs of children entering CPS custody, NARBHA has implemented a comprehensive 24-hour Response system. Through this system, CPS refers children who have been taken into custody and placed in out-of-home care. All children referred are seen by a behavioral health provider in their placement setting within 24 hours of referral. NARBHA and its SAAs have a dedicated 1-800 line through ProtoCall Services that is available 24 hours a day/7 days a week for CPS to utilize to initiate the process.

Process of Engaging and Re-engaging Referral Sources

NARBHA and its SAAs/TAAs network actively engage and re-engage if necessary, all consumers and other referral sources to help ensure that all individuals receive necessary behavioral health services.

Methods of Engagement/Mechanism to Ensure Compliance:

- NARBHA communicates the referral process, along with a provider directory, to all members and other referral sources via memorandums with instructions regarding how to access services at SAAs/TAAs, NARBHAA policies/procedures on referral processes, and the NARBHA Member Handbook. NARBHA monitors providers to ensure these are distributed through regular Eligibility and Enrollment record reviews.
- NARBHA, and its SAAs/TAAs, build positive working relationships with potential referral sources such as AHCCCS Health Plans, CPS, Division of Developmental Disabilities (DDD), juvenile probation, adult probation, and Arizona Families First. Activities include identified contact staff at the SAAs/TAAs who are responsible for incoming referrals, community/stakeholder meetings, and routine communication on status of referrals. NARBHA monitors to ensure that these relationships are being fostered through quarterly reviews of complaint, grievance, and appeal data.
- SAAs/TAAs have enhanced their waiting rooms to be more culturally sensitive and welcoming. NARBHA monitors this activity via annual site visits to each of the waiting rooms.

Methods of Re-engagement/Mechanisms to Ensure Compliance:

- If a person has refused services or has failed to appear for their first scheduled service, the SAAs/TAAs make documented attempts, by telephone or in person, to contact the referral source (person, legal guardian, or organization). If those attempts are unsuccessful, a letter is sent requesting contact unless there are other existing

safety concerns. This is monitored at six month intervals through the ADHS Independent Case Review (ICR) and the NARBHA Case File Review.

- Children, persons identified as seriously mentally ill, pregnant substance abusing women, or any person determined to be at risk of relapse, decompensation, deterioration or potential harm to self or others, require additional re-engagement efforts. Those include contacting family, neighbors, law enforcement, other state agencies or others who may have information on the person's location and condition to the extent allowed by state and federal confidentiality laws, and by initiating a pre-petition screening or petitioning for court-ordered evaluation and treatment if the person appears to meet clinical standards as a danger to self, danger to others, persistently or acutely disabled, or gravely disabled.
- NARBHA SAAs/TAAs provide follow-up services to ensure individuals are re-engaged into the system after inpatient stays, crisis episodes, refusal of medications, or releases from jail. NARBHA monitors performance relative to access to care timeliness standards through the ADHS/DBHS Quality Improvement Project, Independent Case File Review, and the Correctional Officer Offender Liaison (COOL) program measures.
- SAAs/TAAs employ techniques of motivational interviewing (effective strategies for behavioral change, to include the six states of change: pre-contemplation, contemplation, determination, action, maintenance, and relapse) in order to reaffirm that treatment considers the perspective of the individual and motivates them toward recovery. Training on this technique is an ongoing activity at the SAAs/TAAs.

It is only after all attempts noted above have been made to re-engage individuals into the system that a referral is closed out by the SAAs/TAAs. At that point, the referral source is notified of the referral disposition no more than 30 days following the initial request. Of the potential members who are not enrolled after a referral has been submitted, approximately 46% are individuals who do not show up for the initial appointment and refuse any further re-engagement offers.

Clinical supervision is best performed by appropriately experienced and credentialed clinicians who are closest to direct service and client care. Thus, this supervision takes place at the service provider level. It is NARBHA's responsibility to ensure that structures are in place for appropriate supervision and that it is occurring regularly and supports high quality of care and the principles described in this RFP. NARBHA requires its contracted providers to have appropriate clinical leadership for effective supervision, including clinical directors and medical directors licensed in the state of Arizona. NARBHA is also responsible for ensuring that providers are familiar with its ADHS/DBHS contract requirements, along with the various principles for serving populations under that contract. Accordingly, NARBHA communicates service performance requirements to providers in a variety of ways, including its subcontracts, policies/procedures, training, quality improvement efforts, and consultation regarding complex cases. NARBHA then monitors the effectiveness of clinical supervision structures and activities through site visits and clinical review activities.

Clinical Supervision

NARBHA has structured its provider network with Service Area Agencies and Tribal Area Agencies (SAAs/TAAs), each of which is responsible for one of nine sub-regions in Northern Arizona and the members residing therein. Each of NARBHA's SAAs is required through contract with NARBHA to ensure that clinical supervision is provided to direct care staff, in accordance with Arizona licensing requirements. NARBHA also requires that each SAA/TAA be accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) as a means of enhancing the clinical supervision process. In addition to these two contractual requirements, NARBHA emphasizes staff training, credentialing, clinical chart review, and other monitoring activities as the primary means of educating supervisors regarding the ADHS/DBHS principles and outcomes that should be included in clinical supervision and ensuring the presence of adequate clinical supervision.

A recent NARBHA human resources initiative focused increased attention on both the quantity and content of clinical staff supervision. Consultant Tom DeStephano, Professor of Sociology at Northern Arizona University, was hired to work with the NARBHA Human Resources Department and with each of the SAAs on staff retention. One component of the report concluded that many clinicians do not feel as though they are adequately supervised, taking into consideration the changes implemented as a result of new projects and initiatives and the many tasks that must be remembered by the average clinician. As a result of the initiative, several SAAs have supported their clinical staff with additional supervision time to review new initiatives and discuss problem situations with behavioral health reciptients, and have reported that turnover has decreased and quality of care has improved.

Training

NARBHA has offered extensive training to educate provider staff, including clinical supervisors, on the Arizona System Principles, the Arizona Children's Vision and Principles, and the Principles for Persons with a Serious Mental Illness (SMI), as well as the other DBHS/ADHS requirements. The implementation plan for any new ADHS/DBHS initiative always includes a provider training component, and in some cases clinical supervisors are specifically targeted to ensure that information can be reinforced through routine clinical supervision processes. For example, NARBHA contracted with Child and Family Support Services from Maricopa County to provide six months of intensive training, coaching, and technical assistance on-site to each SAA. They introduced the basic principles and practices of the Child and Family Team (CFT) model to all child-serving staff and provided intensive coaching and technical assistance to identified Family Involvement Specialists and their supervisors. NARBHA will continue to offer training and technical assistance to supervisors, clinical liaisons, and all other clinicians serving children and their families to ensure that all provider staff have an understanding of the CFT philosophy and practice and that there is a core of staff members at each site with advanced skills available to mentor and provide clinical supervision.

NARBHA also maintains databases that describe all training and technical assistance that has been made available to providers, including formal group sessions as well as one-on-one technical assistance with a provider in more informal settings. These databases include information such as staff trained, pre- and post-test results, and the ADHS/DBHS standard identified in the training or technical assistance.

Monitoring

Department of Human Resources Site Visits

NARBHA's Human Resources Department performs annual site visits with the SAAs to review a statistically significant sample of staff records to ensure compliance with credentialing and training requirements. Records must show that Clinical Liaisons have evidence of ADHS/DBHS-mandated training and that Behavioral Health Providers (BHPs) have

supervised Behavioral Health Technicians (BHTs) for three assessments prior to allowing a BHT to become privileged to perform assessments.

Supervision is documented through supervision logs, which must be completed monthly. These logs are reviewed during the annual Human Resources site visits for compliance with the Office of Behavioral Health Licensure (OBHL) requirement of four hours per month of clinical supervision for unlicensed staff.

Human Resources site visits also review new employee orientations, mandated training requirements, annual performance evaluations, and job descriptions as further assurance that appropriately credentialed clinical supervisors are available, staff are trained in required areas, and clinical staff performance evaluations include assessment of clinical competency.

OBHL licensing reports are also examined as an essential part of the Human Resources site visit process. If practitioners of any type are found to be out of compliance with OBHL standards or any other regulatory or accreditation requirements, NARBHA's Human Resources Department requires the provider to correct deficiencies. SAAs that are out of compliance and fail to successfully complete corrective action plans are ultimately subject to financial sanctions.

Quality Management Department Case File Reviews

NARBHA's Quality Management Department performs a yearly review of approximately 200 of the clinical charts across the system. Assessments are reviewed to ensure that required supervisory signatures are evident and that staff have performed only functions for which they are credentialed. Quality Management staff work closely with the NARBHA Human Resources staff to compare results.

Other Monitoring

NARBHA also analyzes whether encounters received for Clinical Liaison and assessment functions are performed by staff credentialed and privileged to perform these functions. An electronic comparison between the list of qualified staff from the NARBHA Human Resources Department data and the claims received creates a report of any discrepancies. Beginning in fall 2004, this compliance monitoring will result in corrective actions as needed. If discrepancies are not corrected, NARBHA will levy a financial sanction against the agency until compliance is met.

Supervision for Adult/Child/SMI

Over the past few years, the Children's and Adults' Systems of Care have made dramatic changes with a renewed focus on children, persons with SMI, individuals with co-occurring disorders, and their families as the center of the service planning process. As training opportunities become available, NARBHA ensures that the supervisors of the clinical staff at the provider agencies are trained along with their staff, so that they are able to ensure fidelity to the new initiatives.

Clinical Consultation

In addition to the formal clinical supervision structures and monitoring mechanisms that are described above, NARBHA Clinical Operations staff are involved with clinical consultation in a variety of ways. Clinical consultation to other NARBHA departments, SAAs/TAAs, and fee-for-service agencies ranges from specific case consultation to technical assistance on systems-related issues. Consultation may include response to provider and stakeholder inquiries regarding complex cases, informal feedback from clinical record reviews, feedback related to quality management results (e.g., response to critical incidents), clinical oversight of member complaints and complaint resolutions, and regular Medical Director and Adult and Child Services meetings that occur with representatives from NARBHA and the SAAs/TAAs on an every-other-month basis.

Assessment and Service Planning

NARBHA's strategic plan for FY04-05 includes a goal to "*Increase member and family involvement in the care system by defining member and family involvement in NARBHA's committee structure, projects and initiatives, developing a family education module and implementing the adult team process."* NARBHA embraces the need for family involvement throughout treatment – specifically during the assessment and service planning process, and has encouraged family involvement through training, technical assistance, and the use of printed materials. The Arizona System Principles, Arizona Children's Vision and Principles, and the Principles for Persons with Serious Mental Illness emphasize the need for family involvement and are the cornerstone for guiding treatment throughout the NARBHA system. Education about mental illness and its treatment is essential for NARBHA's members and their family.

Children's Involvement with Family Members

On the 2004 Independent Case Review, Item 3b – Staff actively engage the family in the treatment planning process, NARBHA's score for children was 100%. Child and Family Teams have been a part of NARBHA's children's initiative for over three years. NARBHA was one of the first Regional Behavioral Health Authorities (RBHAs) to pilot the Child and Family Team process. During planning and design for this new initiative, NARBHA had the foresight to envision the need for staff at the local clinics to be skilled in involving family members in the service planning process. HB2003 funding was utilized to support the hiring *Family Involvement Specialists* at all of the SAAs. Family Involvement Specialists are responsible for working directly with children and their family members in order to facilitate the Child and Family Team and develop an individualized, strengths-based, culturally competent service plan.

Family Involvement Specialists must possess the following competencies:

- Ability to effectively engage children and families, in a culturally competent, strengths based manner
- Ability to elicit child and family goals and facilitate the implementation of services and supports in ways which effect the best outcomes for the child and family
- Ability to view services and supports as driven by the child and family needs and not the availability of services
- Ability to be a model of unconditional commitment to a child and family by partnering with family members and working closely with local parent support and advocacy groups
- Knowledge of and advocate for community-based services and non-categorical supports
- Ability to resolve conflicts at the team level and be able to effectively use supervision and management for further conflict resolution when needed

Adult Involvement with Family Members

One of the purposes of an adult team is to improve a member's satisfaction and treatment outcomes by involving the member, family members and other significant relationships in the design, development, and oversight of the individual's treatment and recovery plan. Involving and engaging family members and other significant individuals is an important part of the assessment, treatment, support, and recovery of all adult members. NARBHA's providers employ Clinical Liaisons and other staff who are trained in the ADHS/DBHS assessment process, and whose job is to involve and engage all individuals who are significant to the member's service planning process and to treatment. Family members, in particular, bring accumulated knowledge about the individual to these teams and to the assessment and service planning processes, and have information and perspectives that are helpful. NARBHA's providers are aware of the need to consider and utilize as appropriate, information received from a member's family and significant others, and have been trained that information regarding members is to be shared in accordance with ADHS/DBHS policy, confidentiality and HIPAA rules, as well as Federal requirements.

Family members, when effectively engaged and involved can aid in the member's recovery by:

- aiding in crisis situations
- assisting with the understanding of a member's preferences in order to aid in engagement activities
- providing family support in order to ensure an effective voice for the member in the assessment and service planning process
- identifying and helping to address and resolve other potential barriers to active participation (e.g., transportation, child care responsibilities) of the member and his/her family

- discovering and assessing a member's and family's strengths
- discovering a member's and family's goals, and the supports and/or services needed to reach those goals
- participating in joint decision-making

- communicating with other family members if agreed to by the member
- advocating for the member

Many of NARBHA's members are without the support of their family due to disaffiliation. Other adult members have expressed concern about involving family in their care because of concern that their family would be upset by the nature of their issues. However, NARBHA and its provider staff understand that unless the member does not wish family involvement or it is contraindicated by family circumstances, family involvement must be encouraged with the adult population. In an effort to improve NARBHA's performance related to family involvement, NARBHA has stepped up its efforts to provide technical assistance and training on the importance of utilizing family members in the process of service planning. A Performance Improvement Plan was undertaken this past year, with improvement in scores related to family involvement noted. NARBHA's Performance Improvement Committee will continue to revise that plan, with further recommendations to be added during the fall of this year.

During the upcoming year, NARBHA will partner with its consumer run agency – Northern Arizona Consumers Advancing Recovery and Empowerment (NAZCARE) to implement a curriculum designed by the National Alliance for the Mentally Ill (NAMI), to offer training to providers, consumers, and their family members on the importance of family involvement in assessment, service planning, and recovery. NAZCARE has already done an excellent job of working with consumers on how they can become more involved in their own service planning. This work, along with efforts made by NARBHA staff, has resulted in an excellent Independent Case Review (ICR) score of 99.4 for member involvement in their own service planning.

Technical Assistance/Training and Monitoring of the Family Involvement Process

NARBHA requires its providers to abide by all ADHS/DBHS policies and procedures, several of which address the specifics of the assessment and service planning process. In order to monitor compliance with this policy, NARBHA analyzes the results of the ADHS/DBHS Independent Case Review (ICR) and conducts its own Case File Review six months after the ICR. As a part of NARBHA's Case File Review, Quality Management staff review member records in order to determine whether there is evidence of family involvement in the assessment and service planning process. NARBHA recognizes the need to provide continued technical assistance, training to - and subsequent monitoring of - its SAAs/TAAs on the need for Family Involvement in assessment, service planning, and service delivery for its members. Efforts to provide this type of assistance have been stepped up over the past two years and include the following:

- Clinicians at all of NARBHA's SAAs/TAAs have been trained on the new ADHS/DBHS assessment and service plan requirements, including family involvement in assessment and service planning
- Providers include review of assessments and service plans for evidence of family involvement in their internal chart review processes
- NARBHA has developed training materials on the importance of family involvement and provided trainings to staff who work with both children and adults
- NARBHA's Family Support Specialist, in collaboration with parents, families, and consumers throughout Northern Arizona, developed a brochure on family involvement printed in both English and Spanish, which has been handed out in numerous venues.
- Wording has been added to the ADHS/DBHS Service Plan under the "*Person's Strengths*" section. The wording prompts staff to include information on family members who are involved in service planning.
- NARBHA's Clinical Operations and Quality Management Departments jointly developed a training video to be used in conjunction with the ADHS/DBHS Assessment Training Curriculum. The focus of the NARBHA video is on family involvement and culturally competent service planning.

NARBHA will ensure that children in the care and custody of the state and children who have been adopted through the state and in the Adoption Subsidy Program have their behavioral health service needs met through:

- Partnering with state agencies to develop and implement programs specifically designed to meet the unique needs of children in state care
- Continued development of capacity and expertise to serve the unique needs of the foster and adoptive care populations

Data referenced below were taken from the Arizona Department of Economic Security/Child Protective Services, "Child Welfare Reporting Requirements Semi-Annual Reports" for April 1, 2003 through March 31, 2004.

Children in the Care and Custody of the State

The number of reports received through the Child Abuse Hotline of the Arizona Department of Economic Security/Child Protective Services (ADES/CPS) has been steadily increasing over the past few years. According to data reflected in the above referenced reports, 38,922 calls were received statewide for that timeframe. Statewide ADES/CPS statistics show the primary cause of referrals reflect, 32.3% physical abuse, 59.8% neglect, 5.9% sexual abuse, and 2% emotional abuse. As of March 31, 2004 there were 8,246 children in out-of-home care statewide. ADES/CPS in District III and Mohave County in District IV, which together represent the NARBHA service area (excluding the Navajo, Hopi and White Mountain Apache Reservation), placed 839 children in out of home care during the report period. There are currently 563 children in out-of-home placement in the NARBHA region.

National data show that children who are placed in out-of-home care as a result of exposure to a variety of factors such as poverty, maltreatment, multiple placements, and substance exposure, are more likely to experience poor physical health, developmental issues, behavioral health disorders, and increased risk for involvement in the juvenile justice system. Children who have been abused and returned to parents without subsequent intervention are also at high risk of being seriously re-injured. Having a coordinated system of care is an important factor in helping to ameliorate the negative effects and improve outcomes for children and families served.

Nationally, there is increased recognition for a more global perspective about the trauma of removal and the multiple losses these children experience in addition to their history of abuse and/or neglect. NARBHA is working to develop specialization for meeting the unique needs of children in the foster, kinship, and adoptive care populations through the provision of training on these unique needs including permanency, reunification, kinship needs, attachment, transition, dependency issues, and early childhood interventions. The provision of behavioral health services in Arizona has undergone tremendous system changes and many best-practice initiatives, including evidence-based practices, have been implemented with the development of the Arizona Children's Vision and Principles over the last few years. The child welfare and behavioral health systems are now facing further opportunities for multi-systemic changes with the report and action recommendations from Governor Janet Napolitano on ADES/CPS Reform. There is a heightened public and professional awareness of the need for a collaborative, integrated approach to addressing the specialized needs of these multi-system children.

Children Adopted Through the State and in the Adoption Subsidy Program

In 1975, the Arizona Adoption Subsidy Program was created by the state legislature; funds were appropriated to encourage families to adopt special needs children by providing monthly maintenance payments and special services for these children who might otherwise not be adopted. The subsidy agreement provides four types of subsidy: 1) medical coverage through eligibility for Title XIX AHCCCS/Medicaid; 2) monthly maintenance subsidy; 3)special services subsidy; and 4) reimbursement of nonrecurring adoption expenses. Behavioral health services must be obtained or coordinated through Regional Behavioral Health Authorities (RBHAs), private insurance, or Medicaid (for out of state/US citizens). Services will be provided or coordinated by the Service Area Agencies and Tribal Area Agencies (SAAs/TAAs) in the NARBHA region.

Children who will be or have been adopted through the State and are in the Adoption Subsidy Program, require access to many of the same resources and supports utilized by any child in the custody of state agencies. In order to preserve adoptive placements and support a foundation for adopted children with special needs to successfully achieve stability and permanency, it is imperative for the system to be responsive to their unique behavioral health needs. When a child transitions from state care to adoption, administrative functions shift to Adoption Subsidy.

Partnering with State Agencies

NARBHA recognizes the need to continue to focus on maintaining foster and adoptive children in the community through offering an array of timely, high quality, intensive, wrap-around services and facilitating on-going partnerships with other state agencies. Through these partnerships, a number of collaborative programs have been developed and will continue to be implemented in order to meet the unique needs of children in state care.

Collaborative Meetings and Trainings

NARBHA staff meet every other month with ADES/CPS Management in Districts III and IV to discuss on-going system improvement issues for the region. In addition to these meetings ADES/CPS staff are regularly invited to participate in NARBHA-sponsored training events that offer cross-training and communication opportunities between the agencies and providers of behavioral health services.

NARBHA additionally meets every other month with the ADES/Division of Developmental Disabilities (ADES/DDD) management to discuss on-going system issues for cross-system children. NARBHA and ADES/DDD have collaborated over the past year to host quarterly "Brown Bag Lunch Trainings" on issues faced by the developmentally disabled population, which includes children in the care and custody of ADES/DDD and ADES/CPS, at SAA sites throughout the network. TAAs also participate in this process. The goals are to increase collaborative relationships at the local level and increase skills in working with this population.

One of NARBHA's committees, the Regional Children's Council of Northern Arizona, is comprised of a wide range of stakeholders, and meets quarterly to discuss the children's system of care for the region. The Council recently approved the development of the Barriers Resolution Subcommittee, which will meet monthly to review and resolve identified systems barriers elevated from Child and Family Teams, parent groups, and other community, state agency stakeholder meetings, and complaint, complaint resolution and grievance and appeal trending. The Subcommittee has a core membership including ADES/CPS, ADES/DDD, NARBHA, education, and parent/community group representation. Barriers and resolutions will be tracked in a database and will be reported quarterly to the Regional Children's Council and to the NARBHA Provider Performance Committee. The Subcommittee will maintain a focus on and commitment to the Arizona Children's Vision and Principles as the foundation for barrier resolution.

Urgent Assessment, Engagement, and Service (24-Hour Response)

In August of 2003, NARBHA implemented pilot sites for the 24-Hour Response system for children removed from their homes and in the care of ADES/CPS. In October 2003, the system was implemented network-wide. The purposes of the process include, 1) stabilize crises and identify immediate safety needs and presenting problems of the child, 2) provide direct therapeutic support to each child to help reduce stress and anxiety and offer a coherent explanation about what can be expected in the near future, 3) provide direct therapeutic support to each child's new caregiver including guidance about symptoms to watch for, helping the child adjust, and to provide a reliable contact in the behavioral health system, 4) initiate the assessment, enrollment, engagement process, and development of the Child and Family Team, 5) provide ADES/CPS with findings and recommendations related to the assessment, interim service plan, and if noted, as to placement visitation and services prior to the initial Preliminary Protective Hearing.

In February 2004, NARBHA designed and implemented a comprehensive tracking and reporting database to improve the program. NARBHA centralized 24-Hour Response referrals from ADES/CPS through a dedicated 1-800 line at ProtoCall Services (a NARBHA contracted crisis service provider). ADES/CPS case managers call one number to request the response; the call is routed to the correct SAA to initiate the response. Behavioral health providers then see each child within 24-hours of ADES/CPS referral. Through development of the tracking system, NARBHA is able to track a number of items including, the age ranges of children referred, the location at which they were seen, eligibility and enrollment status, timeliness of Child and Family Teams, average time to ADES/CPS referral from removal, average time from referral to face-to-face response, and response locations. NARBHA will continue to monitor and improve the process in collaboration with ADES/CPS.

Since implementation, the following data has been captured:

- Between August 15, 2003 and June 30, 2004, 250 children were seen through the 24-Hour Response process. This reflects 100% of the referrals made by CPS.
- During the first 6.5 months of 24-Hour Response, prior to implementing the centralized number and tracking, data shows 85 responses. In the 4.5 months following the tracking, data shows 165 responses. This reflects an average monthly increase of 35%, which primarily represents improved data tracking.

Data collected between February 15, 2004 and June 30, 2004 reflects the following:

- 55% of the responses were for children ages 0-6.
- 94% of the children were seen in settings other than the office.
- The average length of time from call to the first Child and Family Team was 11 days.
- Only 73% of the children were Title XIX eligible.

Therapeutic Foster Care (TFC)

Like other states, Arizona has seen an increasing need in recent years for foster care programs for children in the care and custody of the state that can serve children who require specialized clinical and supportive interventions. NARBHA partnered with an existing ADES/CPS District III foster care program in July 2003; providing Medicaid funding and substantial clinical and other supports, thereby rapidly expanding capacity in this new partnership. Now known as "Therapeutic Foster Care" (TFC), this evidence-based practice promises many children a chance to experience and practice the intimacy of family connections related to longer-term positive stability and permanency. Without TFC, these children might otherwise have been placed away from their communities, including out-of-state, and in more restrictive, institutional settings. Over the past few years, NARBHA has had very few children placed out-of-state and is committed to continuing to develop local treatment resources.

NARBHA, in collaboration with foster parents, provider agencies, and ADES/CPS developed a TFC Handbook and participated in the state-level workgroup to develop the TFC Practice Improvement Protocol (PIP). NARBHA plans to distribute the ADHS/DBHS TFC PIP to the provider agencies and incorporate it into the Handbook and practice once it is released. In addition to the Handbook, Therapeutic Foster Care providers receive training, in-home family support and therapeutic consultation services, as well as fair rates of compensation for provision of individualized care for children with serious emotional disturbances. In order to anticipate the unique needs of children entering foster care, NARBHA intends to continue to develop local TFC services and increase bed capacity, through continued collaborative meetings in ADES/CPS Districts III and IV and continued contracting with ADES/CPS provider agencies for recruitment, retention, and development of the program.

NARBHA recognizes the need to anticipate the unique needs of children entering foster care, and thus, the need to continue to develop TFC home capacity. As of June 30, 2004, NARBHA had developed 13 homes with 38 beds. NARBHA plans to continue to recruit additional homes through contract provider agencies with a focus on retention in the ADES/CPS District III region and program development and expansion in ADES/CPS District IV (Mohave County).

Co-location

In line with Governor Napolitano's plan for CPS Reform, one of the SAAs has co-located with CPS in Fredonia, and NARBHA intends to have behavioral health staff co-located on-site at several additional ADES/CPS offices. The intent of the co-location initiative is to establish a more effective cross-system partnership to meet the unique needs of children and families involved with ADES/CPS. This will be accomplished through the development of increased understanding between agencies, increased expertise for the population served, and facilitation of the provision of behavioral health services to the ADES/CPS population as measured by access, enrollments, timeliness, provision of covered services, decreases in utilization of higher levels of care, and review of ADES/CPS-specific complaints, problem resolutions, and grievances. NARBHA also plans to issue an initial collaboration satisfaction survey as a baseline measure and reissue at follow-up intervals to measure the changes in perceptions of collaboration between local behavioral health and ADES/CPS staff.

Continued Development of Capacity and Expertise

NARBHA offers regular training and technical assistance in a variety of ways to its network providers. Many of the trainings are offered separately to the TAAs recognizing their distinct culture. NARBHA is committed to incorporating ADES/DBHS Clinical Guidance Documents along with the Arizona Children's Vision and Principles into all relevant training and technical assistance opportunities. NARBHA has offered a number of training opportunities as part of the House Bill 2003 and Federal Block Grant Training Plan over the last fiscal year. Examples of past trainings specific to the foster and adoptive populations are:

- In November and December 2003, NARBHA hosted a Trainer Training on Child and Family Team (CFT) Facilitation by the Child Welfare Policy and Practice Group. Representatives from ADES/CPS participated along with staff from the SAAs. Between January and May 2004, eight, two-day community-based trainings by Child and Family Support Services were held in local communities throughout the region. Local ADES/CPS staff, foster

parents, Court Appointed Special Advocates, parents, behavioral health, school, and other child serving community agencies were trained on the CFT Process. In addition, all of the SAAs participated in intensive on-site training and coaching on CFT philosophy and practice.

- NARBHA developed training materials on CPS and the 24-Hour Response Process including a flowchart for training behavioral health providers and stakeholders to improve cross-system understanding, establish clear guidelines, and create and maintain a focus on the purpose and child-driven need of the model.
- In April 2004, NARBHA hosted two one-day trainings entitled "Responding to Foster Children and Foster Families". Dr. Richard Delaney, a national expert in child welfare, presented to approximately 140 representatives from the provider network and a wide-range of key community stakeholders. The intent of the training was to improve provider and CFT member understanding of the unique needs of foster children.
- Beginning in March 2004, ADES/CPS District III requested NARBHA participation in the County Attorney/Attorney General directive to establish a "Justice Center" in Colorado City, a remote, rural community along the Utah/Arizona border. NARBHA and SAA staff have been participating in the community development meetings in that area to develop this dual county/state, multi-agency service plan. Part of the behavioral health agreement was to provide CFT Facilitator Training to community members and the multi-agency staff that will be serving shared-system children in the area, which was completed in September 2004.
- Trainings are also being provided for the TAAs and Tribal Social Services. In FY 2003-2004 Jon Eagle, a national expert on wrap-around philosophy and practice worked with Apache Behavioral Health Services and other local Tribal social services and community providers. Training was completed with Hopi Guidance Center and Hopi Social Services in September 2004 on CFT facilitation.
- NARBHA offered scholarships for SAA staff to attend the Annual Arizona Child Abuse Prevention Conference. The focus was on foster care with Governor Napolitano and ADES Director David Berns both giving keynote addresses. NARBHA also provided scholarships for foster parents and SAA staff to attend the Infant-Toddler Mental Health Institute in September. The first day of the training was specific to young children in foster care.
- NARBHA plans to purchase within this fiscal year, the "Shared-Parenting" curriculum from the Child Welfare Institute in order to explore opportunities for development of Enhanced Therapeutic Foster Care in the region. In this program foster parents are trained to work directly with birth families.
- In addition to trainings, NARBHA has created a 24-Hour Response Overview and Arizona Children's Vision and Principles document that was mailed to all foster homes in the region in September 2004 in order to enhance caregiver understanding of the process.

Special Foster Care Populations

NARBHA is working to ensure that its provider network possess sufficient capacity and skills to serve the needs of children and their families. Network development efforts are on-going to establish contracts with community service agencies that offer support and rehabilitation services. These services include but are not limited to respite, living skills, personal assistance, health promotion and family support. NARBHA will continue to monitor network sufficiency and work closely with state agencies to identify network gaps and enhance partnerships to develop creative resources when needs are identified. All provider agencies have access to the current Covered Services Guide to identify types of services to consider. NARBHA's Community Supervisor and Wellness Department also assists in identification of resources and gaps at the local levels and works with the parent-led OCSHCN groups (Office of Children with Special Health Care Needs) to help with community-based development and resource identification.

NARBHA has also initiated the process for identifying SAA provider staff with experience and expertise within identified specialty areas. In 2001, ADHS/DBHS identified certain specialty areas, which would be most appropriate in helping CPS meet the unique needs of children who have been removed from their homes. NARBHA continues to track these specialty areas in its provider network, which include attachment and bonding, adoption, sexual abuse, sexual offenders, eating disorders, and Post Traumatic Stress Disorder (PTSD). As a result of NARBHA's collaborative effort with the ADES/DDD, NARBHA will also continue to work toward building capacity and ensuring all children in the care of state agencies have access to CFTs led by trained facilitators. Beginning in July 2004, NARBHA implemented an automated system to track Teams led by trained facilitators.

NARBHA has met with Touchstone Behavioral Health to discuss bringing Multi-Systemic Therapy and Functional Family Therapy within the region for substance abusing, dependent, and chronic juvenile offenders as an evidence-based practice. Additionally, Apache Behavioral Health Services received a grant in September 2003 to develop Multi-Systemic Therapy within their service area.

Beyond increasing provider expertise on the needs of the general population of foster children, particular focus will be given over the next two years to meeting the needs of infants and young children in foster care and the needs young adults transitioning into the adult system. Currently, one of the highest percentages of children currently entering ADES/CPS foster care in the NARBHA region are children in the 0-5 population. An increasing number of these are substance-exposed newborns. Through implementation of the 24-Hour Response program, NARBHA is improving the responsiveness of the system of care to this population. NARBHA looks forward to increasing provider expertise in this area through training and technical assistance in-line with any ADHS/DBHS guidance.

There is increased attention nationally on the specific needs of children age 16 years and older who may age out of foster care and face transition to adulthood. National data shows a high percentage of these children experience poor outcomes, including higher rates of criminal justice system involvement, underemployment, homelessness, and re-entry into the child welfare system as parents. NARBHA is committed to increasing the understanding at the CFT level of the need for a concerted multi-agency effort that focuses on the transition, support, and specialized planning needs for this population. NARBHA looks forward to incorporating the ADHS/DBHS Transition to Adult Practice Improvement Protocol into future trainings once it is released.

As a result of the Jason K. Settlement Agreement and the establishment of the Arizona Children's Vision and Principles, the state behavioral health system has been presented with the opportunity to implement profound changes in the system of care to address the needs of Arizona's children and families. NARBHA has focused on the development and successful implementation of these reform efforts through integration of Child and Family Team (CFT) practice. This is being achieved through:

- In partnership with community stakeholders, develop a strong foundation of knowledge and expertise in implementing and sustaining the CFT model as a framework for the provision of services;
- Develop action steps, in collaboration with key agencies, to work toward the achievement of full implementation and practice improvement.

Develop a Strong Foundation of Knowledge and Expertise

The inception of Child and Family Team practice in Northern Arizona, since 2001, represents a major change in the state's philosophy for serving children with serious emotional disturbances. Rather than children being funneled into standard treatment plans, individualized service plans are now developed in partnership with the child and family to fit their unique cultures and circumstances. The Child and Family Team (CFT) includes, at a minimum, the child, family, any foster parents, a behavioral health representative, and any individuals important in the child's life and who are identified and invited to participate by the child and family. In the case of children who may be legally dependent or delinquent, the custodial agency shares selection of team membership with the child and family. This may include, for example, teachers, extended family members, friends, family advocates, healthcare providers, coaches, community resource providers, representatives from faith-based communities, agents from other state service systems, etc. The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child and the needs of the family in providing for the child, and can therefore, expand and contract as necessary to be successful on behalf of the child.

Changing the Nature of Treatment Services

On-going training for CFT participants includes skill development to change the mix of services based on identification of underlying needs and functional strengths, and incorporating these into the treatment planning process. NARBHA is committed to altering the nature of behavioral health treatment through the CFT framework, including developing and supporting the following:

- Focusing on strength-based, family-driven assessment and treatment planning
- Exploring development of evidence-based practices
- Increasing expertise in treating and identifying services for special populations
- Focusing on underlying needs and functional strengths
- Partnering with families and stakeholders to achieve family, community, and system level change
- Collaborating with out-of-home care providers to support CFT practice and improve discharge planning

Prescriber's Role in Child and Family Teams

Prescribers have a defined role in CFTs and actively participate when children have complicated physical and/or behavioral health needs. Service and tribal Area Agencies (SAA/TAAs) are NARBHA's key community-based comprehensive behavioral providers. Prescribers perform comprehensive psychiatric evaluations and actively solicit input from CFT members. Prescribers support the CFT by educating CFT members, in easily understandable language, on prognoses, evidence based practices, risks and benefits of medication treatments, and treatment options for youth. When medications are considered or recommended, prescribers and CFT members collaborate to ensure: the safety and effectiveness of the medication regimen through verbal and written informed consent; clearly defined target symptoms; regular monitoring for responses and adverse effects; coordination of care with other providers; and stakeholders and ongoing psycho-education.

NARBHA's SAA/TAA prescribers, along with other provider staff, were trained in CFT practices and understand and follow the ADHS/DBHS Practice Improvement Protocol (PIP) The Use of Psychotropic Medication in Children and Adolescents, and the ADHS/DBHS Informed Consent standards. On the 2003 ADHS/DBHS Independent Case Review (ICR) NARBHA scored the highest of any Regional Behavioral Health Authority (RBHA) in the state for children, for the performance standard relating to informed consent covering new medications. NARBHA met the ICR standard. In the 2003 ADHS/DBHS Youth Services Survey for Families, 96.7% of parents of NARBHA child members reported giving consent for medications prescribed.

Training and Technical Assistance

NARBHA offers regular training and technical assistance in a variety of ways to NARBHA's SAAs/TAAs. NARBHA is committed to incorporating ADHS/DBHS Clinical Guidance Documents, including the Child and Family Team Practice Improvement Protocol, along with the Arizona Children's Vision and Principles into all relevant training and technical assistance opportunities. The Child and Family Team Technical Assistance Document will be a core component of the facilitator training once it is released by ADHS/DBHS. NARBHA has offered a number of training opportunities as part of the House Bill 2003 and Federal Block Grant Training Plan over the last fiscal year. There were a number of trainings specific to CFT Practice.

In 2001, NARBHA began working with national expert, John VanDenBerg to introduce wraparound philosophy and practice into the network. In November and December 2003, NARBHA hosted a four day Trainer Training on Child and Family Team Facilitation by the Child Welfare Policy and Practice Group. Family Involvement Specialists (FIS) from each SAA and their supervisors, along with representatives from NARBHA and the Arizona Department of Economic Security/Child Protective Services (ADES/CPS) completed this intensive four-day training. At that time, NARBHA also contracted with Child and Family Support Services out of Maricopa County to provide six months of intensive training, coaching, and technical assistance on-site to each SAA. They introduced the basic principles and practices of the CFT model to all child-serving staff and provided intensive coaching and technical assistance to identified Family Involvement Specialists and their supervisors. NARBHA continues to offer training and technical assistance to supervisors, clinical liaisons and all other clinicians serving children and their families to ensure that all provider staff have an understanding of the CFT philosophy and practice and that there is a core of staff members at each site with advanced skills available to mentor and provide clinical supervision.

Between January and May 2004, eight, two-day community-based trainings by Child and Family Support Services were held in local communities throughout the region. Local ADES/CPS staff, foster parents, Court Appointed Special Advocates, parents, behavioral health, juvenile justice, school and other child serving community members were invited to participate to learn about the CFT Process.

Trainings are also being provided for the TAAs and Tribal Social Services. In FY 2003-2004 Jon Eagle, a national expert on wrap-around philosophy and practice worked with Apache Behavioral Health Services and other local White Mountain Apache Tribal social services and community providers. Training on CFT Facilitation was provided to staff from Hopi Guidance Center and Hopi Social Services in September 2004.

Beginning in March 2004, ADES/CPS in District III requested NARBHA participation in the County Attorney/Attorney General directive to establish a "Justice Center" in Colorado City, a remote, rural community along the Utah/Arizona border. NARBHA and Service Area Agency staff have been participating in the community development meetings in that area to develop this dual county/state, multi-agency service plan. Part of the behavioral health agreement was to offer CFT Facilitator Training to community members and the multi-agency staff that will be serving shared system children in the area. This training was provided in September 2004.

Develop Action Steps to Achieve Full Implementation and Practice Improvement

Philosophy and Practice

As previously described, NARBHA has focused on establishing the knowledge base for the CFT model within the provider agencies. Children's services staff at all the provider agencies have received training in the basic fundamentals of CFT practice, in-line with national best-practice models. NARBHA will continue to maintain and enhance knowledge through incorporating existing ADHS/DBHS resources into relevant training and technical assistance opportunities with providers and stakeholders.

Capacity

After three years, NARBHA's Child and Family Team practice innovations have laid a strong foundation for an innovative system of care. Child and Family Teams are in place throughout the region, and family-driven planning is being practiced. NARBHA estimates that at least 600 children are receiving services through CFTs led by Clinical Liaisons, other behavioral health staff, and community facilitators who have been trained in the CFT philosophy and practice. NARBHA has created an additional credential for facilitators, Family Involvement Specialists (FIS), who have received training to lead CFTs for multi-agency involved children. As of July 1, 2004, NARBHA had 26 credentialed FIS facilitators and approximately 40% of the children currently receiving Child and Family Team services are on teams

led by FIS. NARBHA is currently developing an internal plan for the development of CFT capacity for 100% of TitleXIX/TitleXXI children by October 2006, as per ADHS/DBHS requirements

*Credentialed currently refers to facilitators that meet the NARBHA training requirements for a Family Involvement Specialist. As of July 1, 2004, this includes successful completion of one of the following trainings:

1. Vroon-VanDenBerg Principles of Wraparound Training and Coaching (Fall 2001)
2. Child Welfare Policy and Practice Group Child and Family Team Facilitator/Trainer Training; and coaching by Child and Family Support Services (November 2003- May 2004)
3. Child and Family Support Services 4-day Child and Family Team Facilitator Training

In order to more accurately reflect children served through CFTs, NARBHA established a workgroup in June 2004 to look at improving the training and credentialing requirements to more accurately reflect CFTs led by trained staff beyond "Family Involvement Specialists", while still maintaining fidelity to the model. These changes will include the sustainability of training by recognizing Trainers within each agency while also establishing NARBHA-wide standards for the training and credentialing process.

A comprehensive Automated Tracking System was designed and implemented by NARBHA on July 1, 2004 for the on-going tracking of the number children served by CFTs. The system will allow for the tracking of teams led by credentialed facilitators as well as by non-credentialed behavioral health staff. The system will also track the completion of the initial Strength and Cultural Discovery as part of the CFT. This will greatly improve the quality, timeliness and efficiency of tracking and allow NARBHA to more closely monitor CFT capacity.

Fidelity

NARBHA will continue to develop capacity while moving toward a focus on increasing fidelity to clinical practice protocols. Over the next two years, NARBHA plans to begin monitoring and analyzing CFT data through provider reports, chart reviews, guided interviews, and additional training and technical assistance. NARBHA will utilize performance and fidelity data to develop actions to be taken in areas of training, structure, and service provision. NARBHA will balance the needs of maintaining fidelity with being responsive to the unique needs of each family and community.

Feedback and Practice Improvement

In addition to training, capacity development, and monitoring fidelity, NARBHA will continue to be open and responsive to feedback from ADHS/DBHS, stakeholders, providers, and families in local implementation. NARBHA meets every other month with management from ADES/CPS from District III and District IV/Mohave County, which collectively represent the entire NARBHA area, to discuss collaborative processes. Child and Family Team Practice is a standing agenda item at each meeting. NARBHA has developed a Barrier Resolution Subcommittee as part of the Regional Children's Council of Northern Arizona to look at systems issues identified at the CFT level, as well as by stakeholders and families. The Subcommittee will also review trends in complaint, complaint resolution, and grievance and appeal data to analyze any system trends that may be reflective of CFT practice issues.

NARBHA and its provider network recognize that there are critical outreach, engagement and re-engagement activities that are essential clinical practice elements to ensure enrollment and retention of Title XIX and non-Title XIX eligible persons in care. These activities are outreach directed to persons who are at risk for development or emergence of behavioral health disorders, engagement of persons seeking or receiving behavioral health services, and re-engagement attempts for enrolled persons who have withdrawn from participation in the treatment process. Ongoing supportive services strengthen resiliency, promote skills development and encourage and maintain natural supports.

Member Enrollment

NARBHA communicates the referral process, along with a provider directory and Member Handbook to all members. NARBHA monitors providers to ensure these are distributed through regular Eligibility and Enrollment record reviews. Other referral sources, such as schools, Department of Economic Security, probation, or primary care physicians, are made aware of methods to enroll members via regular meetings between these and other stakeholders and providers. These community-based collaborative stakeholder meetings focus on ways to encourage members to enroll and stay enrolled in behavioral health services. Provider and stakeholder collaboration has also been helpful in developing relationships that result in greater stakeholder participation in the Child and Family and Adult Team process. NARBHA ensures that these relationships are being effectively managed at the community level through regular meetings with key stakeholders at the regional level.

Engagement

It is important to engage individuals and their families prior to and in the early stages of the treatment process to increase the likelihood of a successful experience and to avoid situations where individuals drop out of treatment only to re-appear in the crisis system at a later time. NARBHA and its providers believe that persons should be given the opportunity to explore, identify, and achieve their personal goals, and that member engagement should be courteous, welcoming, empathetic, and culturally relevant.

Engagement begins during the first contact with a member and requires that staff communicate with both members and the referral source with a welcoming, engaging, non-judgmental and responsive attitude. Service Area Agencies and Tribal Area Agencies (SAAs/TAAs), which are NARBHA's primary network providers, also have enhanced their waiting rooms to be more culturally sensitive and welcoming. NARBHA monitors this activity through annual site visits to each of the waiting rooms. SAAs/TAAs train their Clinical Liaisons and assessment staff to embrace principles of engagement and utilize the techniques outlined in the ADHS/DBHS assessment training in order to develop a foundation based on trust and respect. An additional training module on Conducting Culturally Competent Assessments was developed by NARBHA and distributed to SAAs/TAAs to be used concurrently with the ADHS/DBHS Assessment Curriculum.

Following the assessment, the Clinical Liaison is the "glue" that provides consistency and continuity to a member's care as they transfer from assessment to service delivery. Their role is to take responsibility for handling member accommodations, such as transportation or scheduling needs that may be required to support their engagement. This professional but compassionate involvement is the beginning of the development of mutual planning for the Child and Family or Adult Team process, which will form the foundation of additional support for the member. Clinical Liaisons are trained to understand the importance of member, family and stakeholder involvement in the team process. Child and Family Team facilitators ensure that a Strengths and Culture Discovery, a component of the assessment, is developed, which reflects the culturally relevant care required to meet a member's needs. A Strengths and Culture Discovery addresses and respects a member's culture, strengths, language, customs, values, traditions, age, socioeconomic class, ethnicity, race and gender and provides information to the member's team so that the team gains an understanding of and respect for, cultural influences and backgrounds.

In line with the Arizona System Principles, the Arizona Vision and Children's Principles, the Adult Principles and the Principles for Persons with Serious Mental Illness, NARBHA members are treated with the expectation that they have the potential to achieve success and recovery, while also being assisted in developing hopeful and realistic goals. NARBHA providers have been trained on and employ Motivational Interviewing techniques as an effective strategy for behavioral change which supports meeting individuals at their stage of recovery and includes the person's viewpoint and readiness to change.

Re-engagement

NARBHA recognizes that there certain events after which a member may be more likely to withdraw from participation in the treatment process. Missed appointments may be the most important time to re-engage a member. Clinical Liaisons employ multiple methods and mechanisms to re-engage members to assure compliance with all ADHS/DBHS standards and policies.

- If a person has refused services or has failed to appear for their first scheduled service, the SAAs/TAAs make documented attempts, by telephone or in person, to contact the referral source (person, legal guardian, or organization). If those attempts are unsuccessful, a letter is sent requesting contact unless there are other existing safety concerns. Compliance with re-engagement requirements is monitored through the annual ADHS Independent Case Review and the NARBHA Case File Review.
- Members who have missed routine appointments are re-engaged via telephonic or written contact, or home visits.
- Children, members identified as seriously mentally ill, pregnant substance abusing women, or any person determined to be at risk of relapse, decompensation, deterioration or potential harm to self or others, require additional re-engagement efforts. Those include contacting family, neighbors, law enforcement, other state agencies or others who may have information on the member's location and condition to the extent allowed by state and federal confidentiality laws, and by initiating a pre-petitioning or petitioning for treatment process if the member appears to meet clinical standards as a danger to self, and danger to others, persistently, acutely or gravely disabled.

Additional services are offered by NARBHA SAAs/TAAs in order to provide follow-up services to ensure individuals are re-engaged into the system after inpatient stays, discharge from a residential setting, crisis episodes, service refusal, refusal of medications, and/or releases from jail.

NARBHA supported the development of the Northern Arizona Consumers Advancing Recovery and Empowerment (NAZCARE), a consumer operated recovery program. NAZCARE has a consumer staff member from each of its recovery drop-in centers assigned as a liaison to each NARBHA SAA. These individuals meet regularly to collaborate on how to increase attendance, engagement, and re-engagement of consumers at the recovery centers. The NAZCARE Warmline (a toll free 800 number) staff also work towards re-engagement by making phone calls to consumers who have stopped participating in their program, and by encouraging participation in on-going activities and in special events. Visits by NAZCARE staff to Level I sub-acute facilities are also made encouraging members to attend the recovery centers in their areas upon discharge from inpatient, and to offer peer support during all phases of recovery. When possible, one-to-one home visits are also conducted.

NARBHA participates in the ADHS/DBHS statewide Performance Improvement Project for persons discharged from a Level I facility. The project focuses on:

- Ensuring that member discharge planning includes access to all covered behavioral health services.
- Timely and appropriate follow-up appointments based on the individual's clinical needs.
- The need for intensive behavioral health services before the onset of a crisis episode.

NARBHA's inpatient Level I sub-acute facilities have established follow-up clinics to serve members upon discharge. Timing of follow-up appointments is based upon the member's clinical need to see a medical prescriber. This is usually within seven days but not more than 30 days post discharge. NARBHA's four Level I sub-acute facilities have established coordination of care processes with referring SAAs/TAAs to ensure that discharge planning is coordinated. For example, Community Counseling Center's (CCC) Level I sub-acute facility is responsible for acute care of adult members from the Little Colorado Behavioral Health Center (LCBHC) region. Every Thursday, CCC's sub-acute medical staff in Show Low meet via telemedicine link with LCBHC outpatient medical and clinical staff (located in Flagstaff, St.Johns, and Springerville) to review all of LCBHC's members who are in the sub-acute facility.

NARBHA has defined utilization management performance standards as of July 1, 2004 for SAAs/TAAs to follow-up with members who are discharged from a Level I sub-acute facility as follows

- Minimum Performance: 50% within 7 days, 55% within 30 days
- Goal: 60% in 7 days, 65% within 30 days
- Benchmark: 72% within 7 days, 80% within 30 days

NARBHA monitors performance relative to engagement activities including access to care timeliness standards through the ADHS/DBHS Quality Improvement Project, Independent Case Review, NARBHA Case File Review and the

Correctional Officer Offender Liaison (COOL) program measures. NARBHA reviews SAA/TAA performance quarterly on this measure. Regular training at the NARBHA SAA/TAA Medical Practitioners Committee and the Adult and Children's Services Committee occurs on best practices related to these standards. Corrective actions are taken as necessary by NARBHA's Provider Improvement Committee.

Outreach for Diverse Communities

NARBHA's Service Area Agencies/Tribal Area Agencies (SAAs/TAAs) are required to engage in culturally appropriate activities that promote and enhance the health and well-being of their local communities, based on specific needs and priorities identified by needs assessment for each area. Various activities are utilized to accomplish this goal such as outreach, screening/early identification, and referral to treatment for substantial behavioral health issues. Referrals to existing community-based resources (i.e. Alcoholics Anonymous, Department of Economic Security, etc.) and collaboration among community providers is also encouraged.

SAAs/TAAs also participate in wellness activities based upon each agency's assessment of specific needs and priority areas. Such activities might include participation in the annual Depression Screening Day, Mental Health Month, National Recovery/Wellness Month, wellness fairs, inclusion of health promotion and wellness information in a member newsletter, free educational seminars and workshops, and other outreach, screening/early identification and referral activities. Wellness activities are also targeted to specific subgroups such as youth in juvenile detention facilities, isolated Native American reservation communities, individuals presenting at community health clinics, and/or isolated elderly individuals at risk for depression.

Residents in GSA 1 have a variety of cultural and linguistic needs. To promote the provision of culturally/linguistically competent services, NARBHA's Cultural Awareness and Diversity Committee (CADC) assesses the needs of communities in the region and develops the Cultural Competency Work Plan. The Cultural Competency Work Plan includes outreach and engagement strategies specifically directed toward culturally/linguistically diverse groups. Examples of recent outreach activities include:

- Development or enhancement of publications and distribution of culturally appropriate information including publication of the Member Handbook in Spanish. NARBHA has also ordered brochures, fact sheets, and posters from the Substance Abuse and Mental Health Services Administration's National Clearinghouse for Alcohol and Drug Information and Community Mental Health Council in Spanish and with a Native American focus and distributing them to SAAs/TAAs, local clinics, homeless shelters, and other agencies that serve this population.

- NARBHA Tribal Area Agencies are located on reservations and are staffed by Native Americans as a means of ensuring culturally appropriate and geographically convenient behavioral health services.

- To enhance collaboration, provide outreach activities and engagement strategies with area Tribes, NARBHA developed the Native American Tribal Liaison position. This position was created in 2002 and acts as the main point of contact among various departments of NARBHA, Tribal Area Agencies, Tribal Courts, and Tribal Social Services departments of various tribes, providing technical assistance, training and representation on committees and in communities. NARBHA's Tribal Liaison also acts as the main point of contact for the Navajo Nation DHS contractor when needs arise.

- NARBHA has recently engaged in a collaborative effort with the Flagstaff Hispanic Advisory Board to create methods of surveying local Hispanic communities on behavioral health needs, to determine where they are currently receiving services, and to provide outreach about services and local referral sources available through the NARBHA system.

- NARBHA is working in collaboration with the local Hispanic and Native American radio stations to inform communities of survey, outreach, and staff recruitment efforts in culturally appropriate terms and language.

- NARBHA is collaborating with White Bison, an American Indian non-profit organization based in Colorado Springs, Colorado regarding sobriety, recovery, addictions prevention, and wellness/Wellbriety learning resources for Native American communities. NARBHA has worked with White Bison to provide Native American specific

materials about September Recovery Month to health care, social service, and other substance abuse recovery providers who serve Native Americans.

- Project Resiliency has been successful in reducing school drop-out rates among high-risk Latino/Native American children in Flagstaff.

- NARBHA is involved in a collaborative effort with the Navajo Nation TRBHA and Community Behavioral Health Services in Page to provide culturally appropriate detox services to the Native American population

- Behavioral health services for Developmentally Disabled clients living on the Navajo reservation are being provided through a collaborative agreement in place between NARBHA, the ADHS/DBHS Navajo Tribal Contractor, ADES/Division of Developmental Disabilities, and the Hopi Tribe.

- The Hopi Guidance Clinic Pa'angni Parenting Classes incorporate traditional practices to introduce and/or reinforce cultural identity to enhance resiliency within the family and the community.

- NARBHA maintains a Region Wide Interpreter Resource List to supplement local interpreter resource lists maintained at each SAA/TAA. The region wide resource was created to assure culturally appropriate interpreters are available for all linguistic and cultural needs of behavioral health recipients and their families, no matter where they are being served. Interpreter services are also available through a source in Mesa when local interpreters are unavailable.

NARBHA has developed and implemented a number of programs and services directly related to behavioral health recipients (members) who are involved in the criminal justice and juvenile justice systems. These programs and services are as follows:

Adults

NARBHA's Service Area Agencies and Tribal Area Agencies (SAAs/TAAs) work with adult members involved in the criminal justice system, from those who are jailed to those who are ready for release from prison.

County Jail Coordination and Continuity of Care

General Jail Services—Pursuant to the ADHS/DBHS contract, all SAAs/TAAs provide behavioral health assessments, crisis assessments, treatment and coordination of care, including psychiatric, medication and discharge planning coordination of care with their respective County Health Department and/or jail staff for inmates. Assessment and treatment services are available to all consumers with a serious mental illness or co-occurring disorder, and is not dependent on Title XIX status, or previous enrollment in the behavioral health system. Based on these assessments, some consumers may become eligible for the Jail Diversion program.

Post Booking Mental Health Jail Diversion—NARBHA developed and implemented Post Booking Mental Health Jail Diversion programs for persons with Serious Mental Illness/Co-Occurring Disorders in Coconino and Navajo County in 2001 and 2002. NARBHA was the only RBHA able to develop jail diversion programs without specifically allocated support from ADHS/DBHS. County sheriff and city police departments, city and county public defenders and prosecutors, superior court judges, local hospitals, behavioral health provider agencies, city and county public fiduciaries, jail nursing staff and jail commanders were among the key stakeholders involved in the successful development and implementation of Jail Diversion programs in Northern Arizona.

Jail Diversion is specific to the Seriously Mentally Ill consumer, and includes those with a co-occurring substance abuse disorder. Persons with a Serious Mental Illness/Co-Occurring Disorder who have been arrested and detained in the county jail on misdemeanor charges are assessed at the jail by the Service Area Agency (SAA) behavioral health professional for appropriateness of behavioral health treatment in lieu of criminal justice charges and jail. Consumers have choice of involvement in the Jail Diversion program as an alternative to legal prosecution. The behavioral health professional, public defender and county prosecutor collaborate to determine consumer appropriateness for the Mental Health Jail Diversion program, including behavioral health treatment recommendations. To identify members who are potentially appropriate for this program, jail staff fax a daily roster of new jail inmate admits to the SAA. The SAA identifies all statewide enrolled members with a serious mental illness through the IGGI (Intelligent Global Gathering of Information) system which allows member enrollment verification across Regional Behavioral Health Authorities. (RBHAs) For non-enrolled persons who present at the jail with symptoms that appear to be related to a serious mental illness, the jail staff contacts the SAA to complete an assessment on these individuals to determine if the inmate has a serious mental illness. The SAA Behavioral health professional submits monthly progress reports throughout the designated period of diversion treatment. Adherence to and completion of the identified behavioral health service plan, for the prescribed length of time, results in the misdemeanor charges being dropped by the legal/criminal system.

Yavapai County Program—NARBHA and its two behavioral health providers in Yavapai County have partnered with the Yavapai County Superior Court and the Yavapai County Adult Probation Department to provide behavioral health assessments in the county jails and behavioral health treatment for substance abusing criminal offenders in lieu of jail. The primary targeted population is third time offenders who risk prison incarceration for a repeat offense, substance abusing pregnant and parenting women with children, and persons with a serious mental illness with a co-occurring substance abuse disorder. A primary desired outcome of this collaborative program is to reduce recidivism through substance abuse treatment and other covered services. Due to the acuity of this particular population, the substance abuse programs most frequently indicated are Residential Substance Abuse Treatment, or Substance Abuse Day Treatment while the individual is residing in either a safe clean and sober home, half-way house, or at jail and released for the day treatment program. Alternatively, Intensive Outpatient with additional treatment services and community support groups are also available to Yavapai County offenders.

Arizona Department of Corrections (ADOC) Coordination and Continuity of Care

As part of a statewide effort to provide a seamless continuity of care, NARBHA liaisons with the Arizona Department of Corrections (ADOC) and Service Area Agencies and Tribal Area Agencies (SAAs/TAAs) throughout Northern Arizona to establish behavioral health services upon release for discharge ready inmates with a serious mentally illness/co-

occurring disorder. NARBHA has staff representation on the statewide committee of the Arizona Council for Offenders with Mental Impairments (ACOMI), which is designed to develop successful behavioral health practice models for offenders during and follow-up incarceration. In a collaborative effort with ACOMI, NARBHA has held public forums in Northern Arizona on Mental Health Jail Diversion to develop additional support and cooperation for the program.

Correction Officer/Offender Liaison (COOL) Program—This program was established approximately six years ago with ADOC funding and is available at all SAAs/TAAs. The program was established for offenders with substance abuse related problems to receive substance abuse and all other covered services upon release to the community as a mandated condition of parole throughout the parolee's community supervision.

Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT) In July 2004 NARBHA submitted a plan to the ADOC, to develop, implement and pilot a SAMHSA/CSAT Best Practice Program for substance abusing criminal offenders. The plan was approved and program development and implementation is scheduled to begin in FY2004/2005. This SAMHSA/CSAT Best Practice Program covers such areas as relapse prevention, integration, coping skills, maintenance, transition planning to the community, ancillary services for transitioning offenders, offender personality self test, and outcome evaluations. NARBHA's plan includes collaborating with the CSAT Pacific Southwest Addictions Transfer Technology Center to develop and monitor the outcome measures, to determine the effectiveness of reducing recidivism for this population, and to determine if this Best Practice program demonstrates more effectiveness in reduction of recidivism than more traditional substance abuse treatment programs.

Support Services

Housing—Housing is an important issue for inmates being released in Northern Arizona who also have behavioral health needs. Affordable, safe, crime free, and "dry" housing (alcohol and drug use prohibited) for substance abusing criminal justice offenders greatly impact successful re-integration into the community. Apache and Navajo County are two of the poorest counties statewide, and have very limited housing and employment opportunities. There are a high number of inmates released to these counties, and NARBHA has therefore targeted service development efforts for inmates released in these two counties. Through community housing stakeholder collaboration, housing has been made available in Navajo and Apache Counties for both male and female substance abusing criminal offenders. NARBHA and its behavioral health providers in Navajo and Apache County coordinate with the community housing provider and the ADOC Parole Officers to develop and implement behavioral health service plans for this population.

Vocational Rehabilitation—All SAAs/TAAs have a Vocational Rehabilitation specialist on staff to provide skills training and employment assistance to members, including those involved with the criminal justice system. Through collaborative efforts between the DES Interagency Service Administration/Regional Service Administration Vocational rehabilitation program and NARBHA, the development of Work Exploration (paid work on and off grounds for NARBHA enrolled consumers) at the Arizona State Hospital (ASH) is under discussion. Work Exploration assists members to develop work skills to better transition back into the community as productive members of the community. Many of these members have a criminal justice involvement history, making it even more difficult for them to attain gainful employment without having the benefit of learning skills while at ASH.

Children and Adolescents

NARBHA continues to develop ways to meet the specialized needs of youth involved in juvenile corrections. This is done through partnerships and collaborations with state agencies including the Arizona Department of Juvenile Corrections (ADJC) and the Administrative Office of the Courts (AOC). NARBHA has also focused on developing capacity and expertise through collaboration with stakeholders and program development.

Collaboration with Stakeholders

The Regional Children's Council of Northern Arizona—This NARBHA committee has a wide-range of stakeholders, including representatives from the juvenile corrections systems. The Council meets quarterly to discuss the children's system of care for the region and recently approved the development of the Barriers Resolution Subcommittee, which meets monthly to review and resolve identified systems barriers elevated from Child and Family Teams, parent groups, and other community, state agency stakeholder meetings, and complaint, complaint resolution and grievance and appeal trending. Barriers and resolutions will be tracked in a database and be reported quarterly to the Council and to the NARBHA Provider Performance Committee. The Subcommittee will maintain a focus on and commitment to the Arizona Children's Vision and Principles as the foundation for barrier resolution.

NARBHA/ADJC Collaborative Project — In March 2000, ADJC and NARBHA developed a project to assist juveniles in ADJC Parole Violator Centers to obtain appropriate entitlements and access to behavioral health services immediately upon discharge. Youth maintain their Title XIX eligibility for 30 to 60 days while in Parole Violator Centers. A protocol was designed to address behavioral health needs for youth in these centers with project goals focusing on coordination of behavioral health services for children that are being released from secure care, reduction in the time it takes to receive behavioral health services in the NARBHA region following release, and improvement in communication and collaboration between NARBHA, SAAs and ADJC. The protocol clearly outlines the responsibilities of SAA and ADJC staff including timelines and tasks for coordination of care.

Program Development and Evidence-Based Practices

Child and Family Teams — Youth involved with the juvenile justice system and in need of behavioral health services are served through Child and Family Teams (CFT) as the foundation for service provision and collaborative service planning. NARBHA continues to develop CFT capacity and enhance Family Involvement Specialist (facilitator) skills to handle the most intensive, multi-agency cases. As part of this plan, NARBHA offered eight, two-day community-based trainings to present information about CFT practice. Local juvenile correction personnel participated in each training.

Multi-Systemic Therapy — NARBHA is working with Touchstone Behavioral Health and AOC to provide Multi-Systemic Therapy (MST) and Functional Family Therapy (FFT) in GSA 1 for substance abusing, dependent, and chronic juvenile offenders as an evidence-based practice. Touchstone has already implemented MST Teams in Coconino County and further discussions are underway for team development in other areas. Behavioral health staff from several Service Area Agencies attended the MST Training hosted by ADHS/DBHS in August 2004 in order to learn more about the practice. Additionally, one of NARBHA's Tribal Area Agencies, Apache Behavioral Health Services, received a grant in September 2003 to develop Multi-Systemic Therapy within their service area. NARBHA has incorporated development and utilization of MST services into the NARBHA Network Sufficiency Plan, which is reviewed quarterly with ADHS/DBHS. Included in the program development discussion with Touchstone, is how to incorporate Child and Family Team philosophy and practice into MST and FFT services.

Juvenile Detention Services — Although, Title XIX children lose eligibility after 72 hours in detention, all of the Service Area Agencies within the NARBHA region provide services to youth in detention in various ways and generally do not disenroll these members from services while in detention in order to more easily facilitate the coordination of care on release. Collaborative agreements and arrangement with AOC for service provision at detention facilities vary by county but are aimed at providing services for youth in need and to provide an improved continuum of care. At sites in Coconino, Yavapai and Mohave Counties, this includes behavioral health staff co-located on-site at detention facilities. West Yavapai Guidance Center worked with AOC and established an intensive 28 day substance abuse program for youth in detention (DSAT – Detention Substance Abuse Treatment). Likewise, Mohave Mental Health Center established an intensive 90 day substance abuse treatment program in collaboration with AOC (YES – Youth Enjoying Sobriety). NARBHA and its provider network are committed to developing enhanced services to youth in detention, and discussion and collaboration with stakeholders addressing these issues continues.

NARBHA recognizes that the problematic issue of substance abuse strains the health care system, tears families apart, leads to violence, child abuse, and crime. As a rural and remote area with high unemployment and poverty rates, Northern Arizona has populations at higher risk of the devastating effects of substance abuse. Throughout its vast 62,000 square mile geographical service area, NARBHA has established a provider network of nine Service and Tribal Area Agencies (SAAs/TAAs) that offer access to an array of substance abuse services to members and their families, as well as training initiatives and performance improvement activities in this area.

Adult Services

NARBHA has a full array of covered service substance abuse treatment services from lower levels of outpatient substance abuse treatment services to intensive outpatient to substance abuse residential; from opioid replacement therapy to detoxification services throughout its five county region. The network includes two Level II residential substance abuse treatment facilities with a capacity of 41 beds. The 19-bed facility in Prescott serves members from Mohave and Yavapai Counties; the 12-bed facility in Flagstaff serves members from Coconino, Navajo, and Apache Counties. These are both dual-diagnosed enhanced programs to meet the needs of members with mental health and substance abuse co-occurring disorders. NARBHA has 78 Level I licensed and detox capable beds dispersed throughout the region as follows: 28 beds in Flagstaff; 16 beds in Kingman; 22 beds in Prescott; and 12 beds in Show Low. There is also a 12-bed rural substance abuse transitional facility (social detox) located in Page.

When a service, or intensity or duration of a needed service, is not available within the region, NARBHA uses single-case- agreements to contract with providers of these services.

Children's Services

Each SAA/TAA in the NARBHA network offers a geographically dispersed array of services for children and adolescents with substance abuse issues.

Individualized Assessment and Service Provision: All providers offer out-patient, individual, psycho-educational group, and family substance abuse counseling services based on assessment of the individual needs of the child and family. Successful approaches for treatment involves the consideration of the youth's developmental level, family strengths and culture, gender, co-occurring disorders, and social, educational, and community factors that increase risks of substance use. On-going assessment and service planning helps the Child and Family Team (CFT) identify and build on the unique strengths and resources of the family system.

Child and Family Teams: The foundation for service provision and collaborative, family-driven service planning is through CFT practice. NARBHA continues to develop CFT capacity and enhance Family Involvement Specialist (facilitator) and other behavioral health professional skills.

Multi-Systemic Therapy: NARBHA is working with met with Touchstone Behavioral Health to provide Multi-Systemic Therapy (MST) and Functional Family Therapy (FFT) in Geographic Services Area 1 for substance abusing, dependent, and chronic juvenile offenders as an evidence-based practice. Touchstone has already implemented MST Teams in Coconino County and further discussions are underway for team development in other areas. Behavioral Health Staff from several SAAs attended the MST Training hosted by ADHS/DBHS in August 2004 to learn more about the practice. Additionally, Apache Behavioral Health Services received a grant in September 2003 to develop MST within their service area. NARBHA has incorporated development and utilization of MST services into the NARBHA Annual Provider Network Development and Management Plan. Included in the program development discussion with Touchstone, is how to incorporate CFT philosophy and practice into MST and FFT services.

Juvenile Detention Services: Several SAAs have collaborative agreements with the Administrative Office of the Courts (AOC) for service provision at detention facilities in their counties. Three SAAs in the NARBHA region have comprehensive, collaborative programming agreements to serve youth in detention. At sites in Coconino, Yavapai, and Mohave Counties this includes behavioral health staff co-located on-site at detention facilities. The Guidance Center in Flagstaff provides individual and group substance abuse counseling for youth in detention. West Yavapai Guidance Center worked with AOC to establish an intensive 28-day substance abuse program for youth in detention (DSAT – Detention Substance Abuse Treatment). Likewise, Mohave Mental Health Center established an intensive 90-day substance abuse treatment program in collaboration with AOC (YES – Youth Enjoying Sobriety) for youth in detention.

Residential Treatment: The Guidance Center in Flagstaff offers a residential treatment program. Admissions may come from anywhere in the region. The primary focus is on substance abuse programming for adolescents. Staff in the facility are trained in CFT practice as the framework for service provision and planning.

Training and Technical Assistance: In addition to individualized service provision and exploration of evidence-based practices, NARBHA will offer training and technical assistance to SAAs/TAAs related to youth substance abuse in line with the ADHS/DBHS Practice Improvement Protocol - *Substance Abuse Treatment in Children*.

Services for Native Americans

White Mountain Apache Tribe works closely with the TAA to provide "Healthy Nations, N'dee Benadesh: The People's Vision", a healthy communities program that addresses substance abuse in four distinct strategies.

Public Awareness: A mass media campaign designed, developed, and produced by community members, providing forty-four weekly adult shows and forty-four teen talk shows each year.

Prevention: Staff and cluster groups, (elders, men, women, community groups, youth leaders) provide substance abuse prevention education, by means of cluster members speaking to the audience, by showing videos on alcohol/drug abuse and other educational material, at the nine schools and seventeen outlying communities for a total of forty educational sessions. The target population is youth, young adults, and service providers.

Treatment: Centrally located Rainbow Center for treatment is designed to accommodate a new family-based approach to recovery. Increased numbers of outreach counselors and added programs will address the needs of the whole individual, his/her workplace, and home environment. Parallel community-based treatment and aftercare options are being expanded, including support groups for women, strength groups for men, and New Directions Personal Development workshops taught by Apache guides in communities across the reservation. The goal of intervention and early identification efforts include a wide variety of clientele from court ordered parents, juvenile offenders, service providers, and adult members of the community.

Relapse Prevention/Aftercare: The goal of relapse prevention/aftercare includes both in-patient and out-patient adults at Rainbow Center, referral to off reservation sites, and field trips. All clients of the Rainbow Center participated in a majority of the events sponsored by Healthy Nations including field trips, conferences, workshops, cultural activities, health fairs, and youth and adult alternative activities.

Training and Technical Assistance

With ADHS/DBHS assistance and support, NARBHA provided "Train the Trainer" sessions to all SAAs/TAAs and other community stakeholders on the federal Center for Substance Abuse (CSAT) Best Practice Model of the American Society of Addiction Medicine (ASAM) PPC-2R Patient Placement Criteria for the Treatment of Substance-Related Disorders. Training rollout included intensive training by David Mee-Lee, M.D., co-author and editor of the ASAM PPC-2R. NARBHA has provided training on the CSAT Best Practice model on treatment, relapse prevention, and community re-integration for criminal offenders with a substance abuse disorder; ongoing trainings on the federal Substance Abuse Prevention and Treatment (SAPT) block grant for substance abusing pregnant and parenting women and Intravenous Drug users; technical assistance for Substance Abuse Peer Support; and technical assistance and training on the ADHS/DBHS Core Assessment to the Arizona Families First providers to improve coordination and continuity of care for Child Protective Service referred substance abusing members.

System Improvement Activities

NARBHA followed-up the training by developing a year-long SAA/TAA substance abuse task force workgroup in FY 2002-2003 to develop a regional implementation plan to improve service delivery system, to remove barriers to treatment, and to improve and expand substance abuse services based upon member acuity and readiness to change.

NARBHA implemented the following initiatives:

- Eliminated fixed lengths of stay in outpatient and residential programs. Fixed-length treatment was determined not to clinically meet the individualized needs of members and negatively impacted capacity in the system. Member continuance in substance abuse treatment services is now determined based upon the individual member need and acuity, which is assessed on an ongoing basis.

- Improving timeframes for members to enter residential substance abuse treatment within 23 days from the date of assessment, and all members in residential substance abuse treatment will be assessed on a weekly basis for continued length of stay.
- NARBHA providers were trained on and implemented Stages of Change and Motivational Interviewing to meet the member where they are at and to assist the member to engage in their treatment and recovery process in a manner that most benefits the member.
- The two residential substance abuse treatment facilities in Flagstaff and Prescott added Chemical Dependency Day Treatment Programs. Residential substance abuse day treatment provides members a lesser restrictive treatment than residential substance abuse and a more intensive level of treatment than intensive outpatient.
- Further expansion also included increased case management services, increased levels of outpatient substance abuse groups, specialty groups for substance abusing pregnant and parenting women, and co-occurring disorder groups.

In a collaborative effort with ADHS/DBHS, NARBHA began a quarterly Substance Abuse Residential Utilization Management Clinical Record Review in FY 2003-2004. The record review measures whether or not 1) members are offered a residential substance abuse bed within 23 days from the date of assessment; 2) follow up, outreach, and re-engagement attempts occur for members who fail to show for residential substance abuse; 3) members who refuse residential substance abuse treatment are offered other appropriate substance abuse treatment services based upon acuity, need, and stages of change; 4) residential substance abuse is the appropriate identified treatment need based upon member acuity; and 5) members who do not receive residential substance abuse placement within the required timeframe receive the most appropriate intensity and array of treatment services indicated until residential substance abuse placement occurs. A full fiscal year quarterly review that was inclusive of technical assistance to SAAs, treatment program improvements, and performance improvement utilization plans, resulted in all SAAs meeting the performance standard.

NARBHA in conjunction with ADHS/DBHS and the State Advisory Consensus Panel for Persons with a Co-Occurring Disorder developed a Regional Integrated Treatment Consensus Panel/Committee. The regional committee developed an implementation plan for integrated treatment for persons with a co-occurring mental health and substance abuse diagnosis. NARBHA, in collaboration with the Pacific Southwest Addiction Transfer Technology Center, engaged a yearlong SAA/TAA taskforce designed to identify barriers to integrated treatment within their individual SAA/TAA systems and to be instrumental in making system changes in order to establish integrated treatment as a system of care delivery at each agency.

As a part of the initiative to implement integrated treatment, NARBHA and five SAA staff were trained in the ADHS/DBHS Train the Trainers co-occurring disorder series. This training was then presented out at each SAA/ TAA, as well as to community stakeholders. It is now a routine training required for all behavioral health clinicians and non-clinical staff that interact or engage with members. A noteworthy result of the taskforce initiative is that all the NARBHA region residential substance abuse programs and psychiatric sub-acute facilities are now dual diagnosis capable or enhanced.

NARBHA has been exploring several options to increase housing availability in Northern Arizona for substance abusing women with children. A limited number of housing units have been made available through a community stakeholder in Apache County for enrolled members. The NARBHA behavioral health providers in the region provide behavioral health covered services to the enrolled women in the housing. Housing expansion to Navajo County for this special population is currently under discussion with community stakeholders, dependent upon available funding. NARBHA is currently exploring facilities in Mohave and Yavapai Counties that have recently opened and serve substance abusing pregnant and parenting women. In addition, NARBHA has set aside funding dollars to pay halfway house stays for this special population during the coming year, and is exploring the need for detoxification programs with its community partners and stakeholders.

Through a CSAT technical assistance grant obtained by ADHS/DBHS a pioneering effort to develop and implement substance abuse peer support is underway. The Guidance Center in Flagstaff was chosen for this pilot project. The peer support program plan was developed with CSAT consultants and ADHS/DBHS technical assistance. NARBHA has provided additional funding and technical assistance to further develop, implement, and improve the program to increase the number of peers and to employ peers as staff.

The RFP defines "best practices" as "evidence-based practices, promising practices or emerging practices" and an "evidence-based practice" as "intervention that is an integration of science-based evidence; the skill and judgment of health professionals; and the unique needs, concerns, and preferences of the person receiving the services. Evidence based practices (EBPs) are not intended to be automatically and uniformly applied, but instead considered as a combination of all three factors."

NARBHA believes that the use of best practices (BP) and evidence-based practices (EBPs) throughout the NARBHA provider network holds the promise of more closely linking scientific evidence of quality practices with clinical practices enabling clinical care to be more family-friendly, effective, efficient, uniform, and predictable. NARBHA selects BPs/ EBPs through alignment with ADHS/DBHS priorities and initiatives, input from members, families, stakeholders, and providers, and through constant surveillance of current practices and trends.

NARBHA's Strategic Plan for FY 2004 has Prioritized these BPs/EBPs

- Implementation of a uniform electronic medical record in accordance with The President's New Freedom Commission on Mental Health, and the Substance Abuse and Mental Health Services Administration's (SAMHSA) protocol.
- Family psycho-education programs, also a goal of NARBHA's Risk Management Plan, utilizing SAMHSA's protocol, the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients With Suicidal Behaviors, and the Department of Veteran Affairs SAFE (Support and Family Education: Mental Health Facts for Families) Program.
- Integration of behavioral health and physical health care, for which NARBHA, in partnership with North Country Community Health Centers, received a $100,000 two-year planning grant from Health Resources and Services Administration (HRSA).

Through its provider network, NARBHA has already implemented the following best practices identified in the DBHS Evidence-Based Practice Improvement Protocol: Multi-systemic Therapy for Adolescents, Dialectical Behavior Therapy for persons with Borderline Personality Disorder, Motivational Interviewing, Cognitive Behavioral Therapy, Supported Employment, Independent Housing with Supports, Supportive Housing, Therapeutic Foster Care, Relapse Prevention, Family Systems Approaches, Solution Focused Brief Therapy, Motivational Enhancement Therapy, Social Skills Training, Naltrexone Utilization, Opiate Replacement Therapies, Behavior Contracting, Texas Medication Algorithm/MEDMAP and the Recovery Model through Peer Support, Wrap Around, and Warm Line services.

After identifying which new BPs/EBPs will be implemented, NARBHA works to ensure that implementation proceeds in a timely fashion by adhering to the following change strategies.

Enlist Leadership Support from Provider CEOs, Medical Practitioners, and Supervisors of Clinicians

- NARBHA begins discussion with provider leadership at Service Area Agencies/Tribal Area Agencies (SAAs/TAAs) early in the planning stages of new practices in order to enlist support and to champion the change within the provider agencies. Anticipated barriers to change are confronted early in the process.
- New practices are discussed at NARBHA's regular provider committee meetings. NARBHA can roll out new practices at many different provider levels simultaneously. The table below illustrates how each group of leaders and staff have input into the development and implementation of new BPs/EBPs.

NARBHA Staff	Provider Staff	NARBHA Committee	Information Presented—Examples	Information Received—Examples
CEO	CEOs	SAA/TAA Directors	Vision of the practice, overall goals and reasons for the change, the potential funding and costs, and the responsible NARBHA staff.	Funding needs, provider staff as point persons to help NARBHA develop an implementation plan that takes into account local expertise, resources, and training needs.
Medical Director	Medical Practitioners	SAA/TAA Medical Practitioners	Research evidence and scientific validity of the proposed practice.	Prior experiences with the practice, confounding patient or system factors.

NARBHA Staff	Provider Staff	NARBHA Committee	Information Presented—Examples	Information Received—Examples
Clinical Director	Clinical/ Program Supervisors	SAA/TAA Adult-Child Services	Process of care, types of clinical staff involved, interfaces with other member-serving agencies, member selection, outcomes, and monitoring.	Training needs, standardization of record documentation, coding clarification, staffing patterns.
MIS Director	MIS Directors	SAA/TAA Management Information System (MIS)	Data collection process, code set mapping, reporting specifications.	Use of data elements, efficiency of data collection- paper vs. electronic, equipment capabilities.
Family Involvement Specialist	Members and families	TBD as part of Strategic Plan goal	Member selection, potential outcomes, confidentiality, family involvement.	Concerns and preferences.

Eliminate Obstacles by Designing the Practice Well and Aligning Incentives

- Designing practices. The NARBHA Medical Director, Clinical Director, and Adult and Children's Program Managers have worked collaboratively with AHCCCS and ADHS/DBHS on the development of most of the practice improvement protocols currently identified in the DBHS Clinical Guidance Documents and Technical Assistant Documents. This enables NARBHA to provide direct input into the guidelines so that the needs of rural Arizona residents and systems of care are considered prior to finalization.

  New processes and programs are referred to the weekly NARBHA Plan and Design Committee. This committee acts as a multi-departmental committee to effectively design and/or redesign internal and provider system processes, projects, plans, and initiatives, and approves internal monitoring tools and network standards.

- Utilizing pilot projects. NARBHA utilizes pilot projects when rolling out BPs and EBPs which are high volume, problem-prone, or high risk. Studies show that providers who are enthusiastic about a new practice are more willing to tolerate early failures or confusion without abandoning the process. This allows NARBHA to learn from the early implementers, correct any problems, and use the pilot project participants as change agents for the rest of the system. Examples of where NARBHA has done this effectively are Child and Family Teams, electronic medical records, Dialectical Behavior Therapy, consumer-run agencies, and supported housing. Other evidence-based practices are implemented system-wide after multiple trainings such as the ADHS Performance Improvement Protocol (PIP) on Co-Occurring Psychiatric and Substance Use Disorders.

- Analyzing gaps and variance with EBPs. NARBHA's 2004 Strategic Plan Goal #6 calls for the implementation of additional evidence-based programs. NARBHA plans to utilize the SAMHSA national registry of research-based practices whenever possible as these practices have outcome measures which can be used for benchmarking. NARBHA staff analyze what gaps exist between the EBPs identified for implementation and current practices.

Examples of how this can dramatically affect the service outcome follow:

- NARBHA's Medical Staff have conducted periodic reviews of medication prescribing patterns on all children/ adolescents receiving medications. NARBHA identifies which members may not be receiving medications according to the ADHS/DBHS PIP Use of Psychotropic Medications in Children and Adolescents practice guidelines. Alerts and corrective actions are then sent out to the prescribers.

  Results indicate a significant and continuing decline in the rates of polypharmacy of 5 or more medications in children since the initiation of the study. The baseline rate was 4.5% prior to initiation, and 1.09% in 2004 - a 76% decline.

- NARBHA also profiles medical practitioners on intraclass and interclass polypharmacy measures as per the SAMHSA EBP Medication Management Approaches in Psychiatry (MEDMAP), DBHS' policy on Medication Use,

and The National Association of State Mental Health Program Directors' Technical Report on Psychiatric Polypharmacy September 2001. NARBHA's Medical Staff review includes aggregated data, physician-specific data, and member-specific data. Outlying medical practitioners have received intensified peer review and polypharmacy education. Since benchmarking began in July 2003, the practice of specific types of polypharmacy has decreased dramatically with little additional efforts other than identifying differences in practice between physicians and the EBP. After adoption and training on polypharmacy guidelines in Fall 2003:

- The number of members, including both adults and children, who are on five or more medications per month decreased by 34% over the year.
- Members, including both adults and children, on 2 or more atypical neuroleptics for more than 60 days decreased by 37.5%.

Aligning and Ensuring Funding

NARBHA also has used financial incentives to encourage BPs/EBPs by allocating substantial funding outside of the normal sub-capitation system, developing the service at the NARBHA level initially and rewarding/penalizing for correct/incorrect implementation. For example, in FY 2003-2004 NARBHA dedicated $500,000 for respite services above the Service Area Agency's (SAAs) sub-capitation in order to encourage its full implementation. NARBHA also implemented consumer-run organizations in 2002 by fully funding, out of NARBHA's administrative budget, the beginning of Northern Arizona Consumers Advancing Recovery and Empowerment (NAZCARE), allowing it to operate until its non-profit corporate status and Community Service Agency designation were obtained. NAZCARE now operates consumer-run services in five communities across the NARBHA region, with a sixth site to open in Kingman in January 2005. NARBHA also hired a grant writer in 2003 to assist in obtaining additional funding for the implementation of BPs/EBPs.

Training Providers Continuously

NARBHA provides training for new initiatives in multiple ways. It utilizes a committee structure to achieve many of its training objectives, since these meetings occur regularly and frequently. Training can be timely, easily updated, and modified. Competency exams for key processes are often utilized and providers may be required to not deliver a particular service without passing. NARBHA broadcasts its trainings over its extensive videoconferencing system which is also linked with University of Arizona and other rural Regional Behavioral Health Authorities (RBHAs). This has allowed for collaborative BP/EBP trainings to be available to rural providers without having to utilize limited resources for travel.

Monitoring Processes and Outcomes

NARBHA plans to choose process measures and outcome measures from the SAMHSA guidelines whenever possible in order to evaluate new BPs/EBPs and to decide on continued funding. NARBHA's prevention programs already are based on BPs/EBPs and have significant monitoring programs. For example, two of NARBHA's rural prevention providers were using a best practice developed in an urban region. One of the prevention providers was not able to demonstrate adherence to the process measures indicating that they were not able to follow the best practice model. The other provider was able to show that they could follow the best practice but they were unable to show good outcomes. NARBHA terminated both projects and determined that this urban EBP model could not be duplicated in a rural setting.

Case Scenario 1

Day 1. Beatrice's Clinical Liaison at Hopi Guidance Center (HGC) receives a distressed phone call from Beatrice's mother reporting that Beatrice is saying she no longer needs behavioral health services, has stopped taking her medication, and is refusing Mom's attempts to bring her to HGC, where she has been enrolled in services for the past nine years for her mental illness. Mom reports that Beatrice lost her job about two weeks ago and that neighbors in Second Mesa, where Mom and Beatrice reside, have witnessed Beatrice walking aimlessly in the neighborhood late at night, alone, talking out loud to herself. Although Mom has been able to get Beatrice to eat at Mom's home or by taking a meal to Beatrice's home, she is concerned Beatrice is not otherwise preparing meals for herself. Also, Beatrice is refusing to get in a car for any reason, is not bathing, brushing her teeth, or combing her hair, and has been wearing the same clothes for several days.

Upon inquiry Mom says that Beatrice does not appear to be a danger to herself or others. However, Beatrice's reported condition does require a face-to-face home visit to determine her acuity and risk, so the Clinical Liaison immediately contacts a Native American clinical crisis staff member at HGC and apprises her of the situation. While the crisis worker departs for Beatrice's home, the Clinical Liaison arranges with Mom to meet the crisis worker at Beatrice's home. Mom has been actively involved in Beatrice's treatment as part of Beatrice's Adult Team, a group that meets regularly to support Beatrice's wellness and recovery. The Adult Team also includes Beatrice herself; Beatrice's Clinical Liaison and psychiatrist; and a peer specialist, another HGC behavioral health recipient who offers advice and support from the consumer perspective. The Clinical Liaison checks with the psychiatrist, who reports that Beatrice attended her last medication appointment six weeks ago and should have a sufficient supply of medication if she refilled her 30-day prescription. The psychiatrist reports that Beatrice had a similar episode 18 months ago when she discontinued her prescribed medication, but says she has been complying with her medication instructions and has stabilized since that episode. The psychiatrist confirms that Beatrice does not have a history of self harm or harm to others, but that the last time she stopped taking her medications she displayed the same symptoms as she is displaying now.

The crisis worker meets Mom at Beatrice's home and Beatrice answers the door after several hard knocks, appearing sleepy and disheveled and having obviously slept in her clothes. The crisis worker assesses Beatrice and finds that she is not a danger to herself or others; however, the crisis worker is concerned about Beatrice's level of acuity. Beatrice says she did not refill her medication because she feels fine and doesn't think she needs medication or behavioral health services any longer.

Beatrice says she can't sleep at night because she is used to working nights as a part-time janitor and stock person at the local gas station/convenience store. She says she lost her job because she was talking to the voices in her head and it scared customers. She says that, because she is used to being up and working at night and feels closed up inside her house, she now goes outside for night walks. She says she feels sad and hopeless since she lost her job, but says she is eating enough because she can eat at her mom's house or her mom brings her meals. She can't remember when she last bathed, brushed her hair, brushed her teeth, or changed her clothes.

The crisis worker inquires as to when Beatrice stopped taking her medication and asks to see her medication prescription bottle. Beatrice says she quit her medication about two weeks before she lost her job; the amount of medication remaining confirms this. The crisis worker explains to Beatrice that HGC can assist her with employment, but she first needs to be assessed by the psychiatrist. Beatrice says she would like to work again and, since losing her job, she has felt ashamed and has quit going to community spiritual events. Beatrice says if she could have help getting a job, preferably her old job back, she would be willing to talk to the psychiatrist, but she won't get in a car and will instead walk to HGC. The crisis worker notifies the Clinical Liaison of the plan to walk with Beatrice and meet Mom there, requesting arrangements for a crisis psychiatric appointment with Mom's involvement.

The Clinical Liaison participates in the psychiatric session and acts as the Hopi interpreter for Beatrice and Mom. Beatrice and the psychiatrist review her change in functioning since their last appointment. Beatrice says she is unhappy with side effects of her medication, so the psychiatrist changes the dose timing to see if that will help. Together they develop a target symptom list so that Beatrice and her Adult Team will know what to expect from the medication. Beatrice is now willing to resume taking her medication.

The Clinical Liaison arranges with Mom to pick up Beatrice's medication refill while Beatrice and the Clinical Liaison talk about employment. The Clinical Liaison observes Beatrice taking her medication and arranges for the peer support specialist to walk Beatrice home and drive the crisis worker's car back to HGC. The Clinical Liaison lets Beatrice know that she would like to come to her home the next afternoon at 1:00 to check on her welfare and reminds Beatrice to start her usual routine for taking her meds in the prescribed dosage the next evening. She also encourages her to shower, brush her teeth, comb her hair, and change her clothes, and offers to have the peer support specialist assist her with these functions. Beatrice prefers Mom's assistance and Mom willingly agrees.

Day 2. The Clinical Liaison visits Beatrice as scheduled, and sees that Beatrice's appearance indicates she has followed through with her personal hygiene. The Clinical Liaison sets an appointment with Beatrice in two days at HGC, setting it up for late afternoon to fit Beatrice's sleep pattern. She lets Beatrice know that the peer support specialist will be checking in on her over the next two weeks. The Clinical Liaison then goes to Mom's home and arranges with her to continue to have Beatrice come for meals at her house or take prepared meals to Beatrice for the next couple weeks until Beatrice is more stabilized on her medications and can resume her own food preparation. The Clinical Liaison also explains to Mom that the peer support specialist will be checking in with Beatrice over the next couple weeks to see how she's doing, and that Beatrice has another appointment with the Clinical Liaison in two days.

Day 4. Beatrice walks to HGC with the peer support specialist for her appointment; Mom meets her there. The peer support specialist's welfare check with Beatrice on Day 3 indicated Beatrice is taking her medications as prescribed though she had to be encouraged to follow through with her personal hygiene.

Day 14. Beatrice attends her follow-up psychiatric appointment, with Mom's and the Clinical Liaison's participation, to assess her stability since resuming her medication. She has been taking her medication as prescribed, is no longer hearing voices, and is now willing to ride in the car with Mom. The peer support specialist has been maintaining frequent welfare checks with Beatrice and has reported to the Clinical Liaison that Beatrice is doing better at maintaining daily personal hygiene, but does require reminders and has not demonstrated an interest in preparing her own meals. The Clinical Liaison talks to Beatrice about attending the upcoming community spiritual event. Beatrice has some hesitation but agrees to go with the understanding that she can leave the event at any time if she feels uncomfortable.

Beatrice wants to know if she can go back to work. The Clinical Liaison says she has spoken with Beatrice's former employer, and that he says he can tell whether or not Beatrice is taking her medication. The Clinical Liaison explains that Beatrice will need to stay medication-compliant in order to keep a job. Beatrice agrees that continuing to work is a goal for her. Her former employer has agreed to resume Beatrice's employment in three weeks, starting with two hours per evening, and then assess with her and the Adult Team how she is doing after 30 days. If she is doing well at that time, the former employer agrees that he will increase her hours back up to her usual four hours per evening. The Clinical Liaison explains to Beatrice that she needs to begin to prepare her own meals and maintain her personal hygiene in preparation for returning to work.

Day 30. At her 30-day follow-up psychiatric appointment with the psychiatrist, Beatrice reports her target symptoms are improved but says she has a hard time remembering whether she took her medication. The psychiatrist discusses with her and her Adult Team the option of starting a long-acting, injectable medication to take the guesswork away and make sure Beatrice can keep her job functioning on track. The long-acting form also typically has fewer side effects. Beatrice and the psychiatrist review the ADHS/DBHS Informed Consent Form and both sign it. Beatrice agrees and they schedule the first dose Mom is relieved not to have to wonder anymore if Beatrice is taking her medication. Mom and the peer support specialist report that Beatrice has been maintaining her daily hygiene without reminders. In addition, Beatrice has resumed grocery shopping with Mom and has begun to prepare her own meals with the exception that she and Mom eat three meals together, which Mom prepares, weekly at Mom's house. Beatrice attended a community spiritual event in her third week and reports that people told her how happy they were to see her attending events again and that she felt welcomed. Beatrice's start date for re-employment is set for the following week. The Clinical Liaison arranges with Beatrice to go with her the day before her start date and talk with her employer together. The Clinical Liaison says she will meet with Beatrice and her employer weekly for the first month of her re-employment to assist Beatrice in job re-entry.

Day 60: Beatrice's work hours are about to increase to four hours nightly. She is happy to be back at her job and says she likes seeing local people who come into the convenience store. The Clinical Liaison has checked in with Beatrice and her employer weekly. Her employer has now joined Beatrice's Adult Team, so he and Beatrice and the Clinical

Liaison all talk at least monthly. Beatrice says that she wants and needs to stay on her medication and likes the injected form. She says she is much happier now that she can work, go to community spiritual events, and care for herself. Beatrice is scheduled for another follow-up appointment with the psychiatrist in 30 days, and is aware that she can see either the psychiatrist or the Clinical Liaison more frequently if needed.

Case Scenario 2

Marshall and his wife meet with Marshall's Primary Care Physician (PCP) at North Country Community Health Center (NCCHC)[1], as part of his regular health care checkup. Marshall's wife, Marion, states that she is concerned about his sadness despite his being on antidepressants. She also brings in a depression screening questionnaire that she picked up at the Flagstaff Mall from The Guidance Center (TGC), the local community behavioral health agency, as part of Flagstaff Community Health Day. She is worried that her husband seems to score high on the ratings but he refuses to answer the questionnaire himself. She reports that she is getting tired of his not helping her with the kids in the evening and that he has already used up all of his sick leave for the school year because he complains of being too tired to get up for work. She tells the PCP that sometimes she, too, is too tired to get up for work, but she does it anyway and can't understand why he doesn't do the same. The PCP reviews Marshall's blood sugar readings and notes that, despite a recent increase in his oral hypoglycemic agent, his blood sugar is ranging from 180-250 mg/dl most days, which is above normal. Additionally Marshall has gained about 20 pounds in the past three months. The PCP has tried Marshall on three antidepressants in the past six months, and is starting to feel that Marshall's condition is exceeding her expertise because usually by now she would be thinking about discontinuing an antidepressant rather than switching. Also, she is worried about possible drug interactions with the other medications Marshall is on. The PCP is starting to get overwhelmed when Marion brings up that Marshall is drinking three to five beers every night. The PCP is now late for her next appointment and clearly sees that Marion wants to keep talking about Marshall, that Marshall hasn't said anything yet, and that the PCP still needs to address Marshall's diabetes and weight gain.

Fortunately, NCCHC's Flagstaff site provides onsite behavioral health services through two counselors and one psychiatrist from TGC, NARBHA's Flagstaff-based Service Area Agency. This NCCHC/TGC partnership is a Mental Health Integration Project (MHIP), funded initially with Tobacco Tax funds and most recently funded by the Department of Health and Human Services Bureau of Primary Health Care (BPHC). This project utilizes the **evidence-based practice model** from the National Council for Community Behavioral Healthcare on Behavioral Health/Primary Care Integration.

The MHIP provides for immediate referral at the primary care facility for consumers exhibiting signs of mental distress or expressing need for counseling. The mission of MHIP is "to improve the physical and mental health of patients by integrating behavioral health services into the primary care setting." The behavioral health providers receive immediate referrals from medical, dental, and other NCCHC staff. They provide short-term behavioral health services such as:

- screenings for behavioral health needs such as identification of persons who have a serious mental illness (SMI)
- crisis assessments
- clinical consultations with medical providers
- follow-up visits to assess patient progress
- patient and family psycho-education contacts
- care coordination with staff at The Guidance Center
- collaboration with other community agencies and resources
- short-term case management for complex patients

[1] NCCHC clinics serve the same region, and many of the same individuals, as NARBHA's Service Area Agencies (SAAs). NCCHC clinics are located in Apache, Coconino, Navajo, and Yavapai Counties. Apache and Navajo Counties are designated Medically Underserved Areas (MUAs). Coconino and Yavapai Counties contain designated Medically Underserved Populations (MUPs). NCCHC satellite clinics are located in communities that are designated as Health Professional Shortage Areas (HPSAs) or MUPs: St. Johns, Winslow, Ash Fork, Seligman, and Springerville. The NCCHC clinics serve over 10,000 active users, 41% of whom are uninsured. Another 49% of NCCHC users are Arizona Health Care Cost Containment System (AHCCCS)/Medicaid or Medicare patients. In the past year, the Flagstaff NCCHC clinic performed almost 17,000 medical encounters and the outlying clinics performed almost 9,000 medical encounters.

The MHIP project has been successful in reaching a large proportion of NCCHC clients. In the last year, the Flagstaff clinic had 2,358 mental health encounters. This equals 14 mental health encounters for every 100 medical encounters. Current statistics at the Flagstaff clinic show that depression is the most predominant mental health complaint.

The PCP tells the couple that she would like some extra help from TGC with the situation. She steps out into the hall and flags down TGC's masters-level counselor, who has been working at NCCHC for the past three years. She briefs the counselor on the situation and introduces her to Marshall and Marion, stating that she had found the counselor to be really helpful in situations such as this and that she would highly recommend they talk with her for a while. The PCP says she will come back after they have talked. Marion is very relieved because she has had a hard enough time getting Marshall to his PCP, and each time she has talked to him about his depression (she hasn't even brought up to him the alcohol part or her suspicions of drug use) he has said, "I'm not crazy!" He then refuses to talk further; she isn't even sure he is taking his antidepressants but she is afraid to tell the PCP.

The counselor explains what her role is at NCCHC and Marion is amazed at how much the counselor is able to get Marshall to tell her. She hadn't realized how bad he is feeling or that he actually felt suicidal a few months ago. The counselor also asks about Marshall's alcohol use in a way that doesn't make him feel embarrassed, and he tells her he isn't using drugs. The counselor educates the couple on the depressant effects of alcohol and how it could interfere with his diabetes control. She also tells them that in depressed people, intoxication can increase the risk of suicide and that she would recommend they give their handgun to one of their relatives during this time. She gives them TGC's 24-hour crisis number, tells them about community resources for alcohol use, and explains TGC's substance abuse programs. Neither Marion nor Marshall thinks that his alcohol use needs a "program," but they take the brochures the counselor gives them and say they will think about it.

In the meantime the PCP calls the TGC psychiatrist who comes to NCCHC several times per month to consult on cases such as this. The psychiatrist recommends switching Marshall to another antidepressant that can be taken in the morning and is more energizing. This might improve his blood sugar since he will get more exercise if he feels more energetic. In addition, this antidepressant does not have the side effect of sexual dysfunction, which can also be a side effect of diabetes. It is available as a generic now and is more affordable. He tells the PCP what the starting dose is and how to titrate it up. He also tells her to call him again if things don't get better within three weeks and they can then decide if Marshall needs a psychiatric evaluation.

The PCP returns to the room and listens as the counselor explains what she discussed with the couple and what she has discovered. The PCP tells them that she has also talked with the TGC psychiatrist about a medication change. She mentions the possibility of sexual dysfunction from his antidepressants and asks if that is a problem. Marshall nods yes and says that he was afraid he was just getting old and that he has been worried his wife would leave him if she found out so he has been staying up drinking beer until she falls asleep at night. Marion starts crying and says she thought he didn't love her anymore. The PCP tells them that poor glucose control also can cause sexual dysfunction, fatigue, and depression. Marion and Marshall are relieved to find out there are things they can do to make the situation better. The counselor says she will meet with them again right after their next PCP appointment to make sure things re progressing and see if there are other needs that they may have.

The PCP is pleased with the outcome. She now is able to turn her attention back to working with Marshall on weight control through exercise and a healthy diet to better control his diabetes. She looks forward to the expansion of the MHIP into the other NCCHC sites. (In July 2004, NARBHA and NCCHC received a two-year planning grant of $100,000 from the U.S. Department of Health and Human Services/Health Resources and Services Administration to replicate this service model at NCCHC's sites in St. Johns and Springerville (Apache County) with NARBHA's Apache County SAA, Little Colorado Behavioral Health Center; and in Kingman (Mohave County) with NARBHA's Mohave County SAA, Mohave Mental Health Center. The grant came with the possibility of a $500,000 implementation grant after the initial two years, which would include telemedicine capabilities for NCCHC to further integrate primary and behavioral health care.)

Case Scenario 3

Day 1. Mohave Mental Health Clinic (MMHC) receives a call from Frank's grandmother, who speaks very little English. A bilingual staff member takes the call. The grandmother explains their concerns, and the staff member

ascertains that the grandparents have legal custody of Frank and that he is enrolled with AHCCCS. An intake appointment is offered and set up for the next day. The grandmother states that she does not need assistance with transportation.

Day 2. The family comes to MMHC and a bilingual Behavioral Health Professional, assigned as the Clinical Liaison, meets with them for the intake and to start the assessment. (The assessment is completed in two sessions over two weeks; however, the risk assessment and Mental Status Exam are completed immediately to determine that Frank is not a danger to himself or others.) The family is given a copy of the Member Handbook. All intake forms are in Spanish. The Clinical Liaison begins the assessment with the whole family and later meets with Frank individually to begin engaging him into the process. The Clinical Liaison describes the Child and Family Team (CFT) process to the family and lets them know a Family Involvement Specialist (FIS) will contact them to set up a time to meet. The Clinical Liaison makes sure they feel comfortable in calling back if they have questions or needs before then.

Day 6. The FIS meets with the family in their home in the evening as per the family's request. During this meeting, the FIS initiates the Strengths and Cultural Discovery and notes a number of things to include in the CFT planning:

GRANDPARENTS **Identified Strengths**	**FRANK** **Identified Strengths**
Grandparents love and are committed to caring for the children.	The school indicates it has not had problems with Frank prior to last year.
Grandparents are willing to commit to the CFT process.	Parents have given legal guardianship to grandparents.
Grandparents have a phone number for Frank's parents.	Grandparents have created a clean, nurturing, structured home environment for the children.
Grandfather works two jobs in order to support his family.	Frank enjoys drawing and is good at "fixing stuff."
The children are all within walking distance from the school and they attend regularly.	An uncle owns a local auto shop and Frank looks up to him.
Grandparents are very involved with their church, which is just a few blocks away.	Frank has no prior juvenile corrections involvement and reports he is not using any drugs or alcohol.
Identified Cultural Issues	**Identified Cultural Issues**
Grandparents are first generation from Mexico.	Frank is bilingual; Spanish is primarily spoken at home.
Grandparents have lived in their community for 30 years.	Grandparents express conservative values and strong religious beliefs.
Grandparents have never received counseling-type services before.	Frank is much older than his siblings and has been in a caretaker role with them before.
Concerns expressed by Grandparents	**Concerns Expressed by Frank**
Feel Frank does not respect them enough	Feels grief and anger over loss of parents
Feel Frank does not appreciate what they do for him	Embarrassed at team sport events with no parent there
Feel embarrassed about asking for help	Blames self for parent's leaving and worries for them
Guilt because the children's parents have failed them; feel responsible for this	Doesn't feel like he belongs at home or at school and doesn't feel he can talk to anyone
Fear Frank will get kicked out of school and worry that they might not be able to care for him	Feels sad and angry a lot and has trouble paying attention sometimes because of this

The FIS asks the family whom they want on their CFT. The grandfather is initially reluctant to have involvement outside of the family but feels more comfortable through discussion of what to expect. The FIS receives releases to contact people to engage them in preparation for the first CFT meeting.

Day 10. After the FIS engages the CFT members in the process, the first CFT meeting is held at Frank's school. In attendance are the grandparents, Frank, the uncle, their pastor, the school counselor, a neighbor who works at the local fire station, Frank's current teacher, and Frank's school counselor. The CFT reviews the strengths that were identified along with their concerns and develops the following Service Plan activities:

- Psychiatric Services: Grandfather expresses reluctance to consider medication for Frank but agrees to a psychiatric evaluation with the MMHC psychiatrist. An appointment is made for two weeks out.
- Family Involvement Specialist: The FIS will continue to work with Frank and his grandparents weekly in their home for support, and oversight of the plan will continue to be provided by the Clinical Liaison.

- Skills Training and Development in School-Based Setting: Grandparents, Frank, and the school agree to work with an MMHC Behavior Coach two to three times per week to help address Frank's behaviors, to improve communication between home and school, and to give consistent consequences. The Behavior Coach will help Frank identify cues and triggers prior to aggressive behaviors and will teach him how to process feelings of sadness and grief. Frank identifies that he will draw pictures to show how he feels and share them with his Behavior Coach, school counselor, or uncle. The grandparents, teacher and uncle all agree to communicate each day by using a daily home/school "report card."
- Natural Support from Neighbor: A neighbor who works at the local firehouse agrees to allow Frank to come in as a volunteer once a week to do firehouse chores and learn about fire safety. Frank expresses excitement about this.
- Natural Support from Uncle: Frank's uncle agrees to have Frank come to his auto shop after school and on Saturdays. He will help build on Frank's skills at "fixing stuff" by beginning to teach him basic repairs and allowing him to work on projects. Frank's daily home/school report card will determine whether he does chores or fun projects at the auto shop. Frank's uncle agrees to attend his soccer games when possible. Frank is surprised but interested.
- Natural Support from Church: The pastor notes he knows of several other grandparents in their church who are raising their grandkids and discusses setting up a way to have them support each other.
- Assessment of Classroom Setting: Frank's teachers discuss his performance changes between this year and last year. Frank used to sit up front next to his best friend, who moved away over the summer. This new school year, Frank is sitting in the back next to a peer he frequently has conflicts with. Frank agrees to a change in seating.
- Crisis/Safety Plan: The CFT comes up with a Crisis Plan for both school and home that includes respite provided by the uncle as needed. Frank also agrees to talk to his Behavior Coach or uncle if he is having problems.

Day 20. The psychiatrist meets with Frank, who reports feeling sad much of the time since his parents left about 18 months ago. This became worse over the summer after his best friend moved away and after he started playing soccer and resenting his parents not being around. He states he thinks about his parents a lot and things he did that made them mad. He worries about them frequently and thinks he may never see them again. He says he feels like sometimes he cannot control his sadness and anger. Frank is diagnosed with Adjustment Disorder with Mixed Anxiety and Depressed Mood. The grandparents decide they do not want to start Frank on medication yet. The psychiatrist comes to the next CFT meeting to discuss Frank's diagnosis, offer consultation on the plan the CFT developed, and advise the CFT of symptoms to watch for and future medication options.

Day 120. Outcome. Services continued as planned, weekly CFT meetings were held, and after four months, the CFT agrees to decrease services. The grandparents ask for CFT meetings once a month at the school for the next two months to see how progress is maintained. The Clinical Liaison will continue to get the CFT together. A review of strengths and progress with the family and team indicates that the plan has been successful.

- Frank connects well with his Behavior Coach. The change in classroom seating helped, and after a month the CFT started to notice changes. Frank's teacher reports he is doing better and with the help provided by the Behavior Coach, the teacher feels more able to respond to Frank when there is a problem. Frank's grades have steadily increased. He has had a couple of fights with peers but was able to talk with his Behavior Coach and his uncle about what triggered his reaction and discuss other ways to respond in the future.
- Frank states he enjoys spending time at the firehouse and at his uncle's shop and wants to continue with both. His uncle has been going to his soccer games. Frank has had no further fire-setting incidents.
- Frank's parents did not follow through with participating in services despite numerous attempts by the FIS to engage them. Frank, however, developed better ways to express his feelings and talk more openly instead of blaming himself or acting out against others. He now feels connected in the relationship with his grandparents.
- Grandfather feels he has control of his family situation and is again able to provide for their needs. He feels Frank is being more respectful. The grandparents intend to continue with the natural supports that have been established with the uncle, the neighbor, the school, and the church.

Non-Title XIX/XXI resources are limited and population growth causes funding for non-Medicaid populations and services to lag behind Medicaid services on a per capita basis. Therefore, NARBHA and its providers must develop strategies to maximize available Non-Title XIX/XXI funding to serve as many consumers and their families as possible in a rational and equitable manner. NARBHA allocates Non-Title XIX/XXI funding across its large geographic area to Service and Tribal Area Agencies (SAAs/TAAs) according to population, which results in proportionate funding across the region. NARBHA also requires that the SAAs/TAAs spread the funding over the fiscal year to assure that services are consistently available at any point in the year. Within the geographic and monthly allocation framework, NARBHA and the SAAs/TAAs adhere to established guidelines when making determinations related to the use of this funding to assure consistency with ADHS/DBHS requirements and regional priorities.

When determining the use of Non-Title XIX/XXI funding, NARBHA and its SAAs/TAAs take into consideration risk, acuity, continuity of care, level of functioning, Center for Mental Health Services (CMHS) and Substance Abuse Prevention and Treatment (SAPT) Performance Partnership block grant requirements, state appropriations, county funds and other priorities that may be periodically established. Based on all of these requirements and parameters, NARBHA uses the following criteria to prioritize service delivery for Non Title XIX/XXI funds.

Priority One

- Seriously mentally ill persons
- Persons, who as a result of a behavioral health disorder, are at risk of dangerousness to self or others (must be enrolled regardless of funding availability)
- Correctional Officer/Offender Liaison (COOL) referrals (must be enrolled regardless of funding availability)
- Persons in need of crisis services
- Pregnant substance abusing women and their families
- Pregnant injection drug uses and their families
- Non-SMI court ordered treatment

Priority Two

- Adults and youth in need of gap services while being transitioned to other programs or providers (members being discharged from acute inpatient care or ASH)
- Services to enrolled adults and youth who have lost their Title XIX/XXI eligibility

Priority Three

- Youth who need behavioral health services and who are at risk of being removed from their home or are involved with the juvenile justice system
- Persons who, as a result of a behavioral health disorder, frequently utilize emergency services
- Persons who, as a result of a behavioral health disorder, have a high level of dysfunction, which can be effectively treated utilizing existing treatment modalities
- Persons needing limited psychiatry services, including one-time evaluation for diagnostic or risk management purposes, or consultation at the request of a primary care physician
- Persons diverted from jail or referred from jail for behavioral health treatment
- Persons with co-occurring substance use disorders and behavioral health disorders who do not meet the already stated above criteria, including COOL enrollees who have completed the terms of their parole

Priority Four

- Persons who would benefit from specialized services provided by specialty programs developed by the SAAs/TAAs as a result of community planning or needs assessment
- All other persons with substance use disorders

Persons with a serious mental illness who are not eligible for Title XIX are a priority population for NARBHA and its providers, and those persons are served through separate ADHS/DBHS funding. However, to the extent the allocated ADHS/DBHS funds are not sufficient to cover needed services for Non-Title XIX persons with serious mental illness, the remaining Non-Title XIX funding will be used for this priority population.

A part of maximizing the availability of Non-Title XIX/XXI is to ensure that no other funding streams are available to pay for needed services by proper application of coordination of benefit requirements. Providers are contractually

required to assess resources according to ADHS/DBHS policies, including identification of Medicare or other third party coverage, screening for potential Title XIX or XXI eligibility, and a person's ability to pay any portion of their own service costs. For persons who are not eligible for Title XIX/XXI services or other benefits, NARBHA's providers follow the ADHS/DBHS co-payment assessment matrix in order to determine the amount to be charged to a person for a covered behavioral health service.

In accordance with ADHS/DBHS and NARBHA policy, providers are also required to screen individuals who present for behavioral health services for possible eligibility for Title XIX/XXI. This process, including the special considerations for persons with serious mental illness, helps assure that entitlements are accessed wherever possible, thereby extending the Non-Title XIX/XXI resources.

NARBHA also works to develop additional and alternative sources of funding to supplement amounts available through ADHS/DBHS, Title XIX/XXI, and other funding streams covered by this contract. These supplemental funds can be used for Non-Title XIX/XXI services and populations, depending on the grant funding restrictions. NARBHA employs a full time grant writer who is responsible for identifying grant opportunities and developing responses. When successful, those funds can be used by the NARBHA system throughout Northern Arizona. The grant writer is also available to assist providers with developing grant responses and coordinating efforts across multiple providers to present the grant request in the most compelling manner. During the last fiscal year, NARBHA and its provider network have been successful in procuring grants of more than $750,000 with current open requests of $1.1 million. The grants are directed at areas such as housing, vocational rehabilitation, telemedicine, and integration of behavioral health and primary care.

Non-Title XIX/XXI expenditures, both over and under ADHS/DBHS funding levels are tracked by the NARBHA monthly Analysis of Expenses report. NARBHA monitors the appropriate application of prioritization guidelines for Non-Title XIX/XXI funding through monthly analysis of SAA/TAA expenditures and service value reports, clinical record review for care determinations, penetration rates analysis and service utilization by funding categories, especially for SAPT block grant populations. Results of these monitoring activities may result in corrective actions as necessary, including shifts in financial allocations.

Access to services is monitored by a review of the data collected on referrals, which do not result in enrollment, to determine the number of persons who were not enrolled for services because they did not meet the prioritization requirements. Results of this monthly report are reported to the Provider Performance Committee. Corrective action occurs when necessary.

NARBHA has delegated the function of securing services for members to its Service Area Agencies/Tribal Area Agencies (SAAs/TAAs) in order to ensure that care decisions are timely, administratively efficient, and made by the people who know the member best. Most behavioral health services do not require prior authorization. Based upon the recommendations and decisions of the SAA/TAA Child and Family Team (CFT) or the member's adult team, services are secured for any and all covered services that address the needs of the member and family, except during the following situations: ADHS/DBHS requires prior authorization before accessing inpatient services in a licensed Office of Behavioral Health Licensure (OBHL) Level I facility (a psychiatric acute hospital, a residential treatment center (RTC) for persons under the age of 21, or a sub-acute facility). Additionally, NARBHA requires prior authorization for Level II Therapeutic Group Homes. When it is determined that a person is in need of behavioral health services requiring prior authorization, an SAA/TAA behavioral health professional (BHP) applies designated authorization and continued stay criteria to approve the provision of the covered service. A decision to deny a service that requires prior authorization must be made by an SAA/TAA physician. The SAAs/TAAs provide 24-hour coverage with psychiatrists for any denials of inpatient/RTC admissions.

Services delivered directly to members by SAAs/TAAs, except as described above, do not require authorization or any notification to NARBHA. When services will be delivered by fee-for-service providers, SAAs/TAAs make the referral to the fee-for-service provider and notify NARBHA of decisions within one business day to utilize these non-SAA/TAA providers so that NARBHA can ensure timely and appropriate payment for those services.

A denial of a request for prior authorization of an admission to or continued stay in, an inpatient facility, RTC, or Therapeutic Group Home facility can only be made by the SAA/TAA physician designee after verbal or written collaboration with the requesting clinician. When requests for prior authorization are denied or at the time an authorization period expires, the SAA/TAA gives the member or guardian a denial notice: "Notice of Action." The SAA/TAA also sends a copy of the denial notice and a "Notice to NARBHA of Denial of Prior Authorized Services (DOPA)" to the NARBHA Quality Management Director so that the member's clinical record can be reviewed retrospectively. The SAA/TAA also must provide notice of the decision to the person or persons requesting the services, including the reason for denial, in ordinary language and document in the clinical record that notice was provided to the person. Before a final decision to deny is made, the member's attending psychiatrist can ask for reconsideration and present additional information.

When a denial of authorization is appealed to NARBHA, the Medical Director or physician designee provides the required review. If it is determined that the service should have been authorized, the SAA/TAA denial is reversed and the service is authorized.

NARBHA's monitoring and quality management processes include retrospective utilization analysis and review of aggregated utilization management data, clinical record review, lengths of stay, readmission rates, and fiscal reports. Utilization review based on clinical appropriateness does not result in retrospective denials by NARBHA when those services, and their subsequent claims, have been delivered by SAAs/TAAs or appropriately secured by SAAs/TAAs on behalf of NARBHA members.

Timelines for making prior authorization decisions are shown in the following chart.

Service Authorization Matrix

Level	Clinical Decision Timeframe	Suggested Length of Auth	Max Length of Auth	BHP Can Auth But Only MD Denies	DOPA Form to NARBHA in 24 hrs	Authorization Criteria
Hospital or Sub-acute	**Emergency:** immediate	**Initial:** 3 days	Max of 30 days	N/A for emergen-cies	No authoriza-tion required	ADHS/DBHS Admission to Inpatient Services Authorization Criteria
	Non-emergency: One hour for new admit or before end of auth period for continued stay.	**Continued**: 7 days		YES	YES	ADHS/DBHS Continued Inpatient Services Authorization Criteria
Level I RTC	**Non-emergency:** 24 hours	**Initial:** 15 days	Max of 60 days	YES	YES	ADHS/DBHS Admission to Inpatient Services Authorization Criteria
	Non-emergency: No later than 10 days before end of auth period.	**Continued**: 30 days		YES	YES	ADHS/DBHS Continued Inpatient Services Authorization Criteria
Level II Therapeutic Group Home (TGH) for Persons under Age 21	**Non-emergency:** 7 days	**Initial:** 30 days	Max of 60 days	YES	YES	NARBHA Criteria (Based on Former ADHS/DBHS) Level II Residential Treatment Center Services Authorization
	Non-emergency: No later than 10 days before end of auth period.	**Continued:** 30 days or up until the next Child & Family Team (CFT) or Individual Service Plan (ISP) review.		YES	YES	NARBHA Criteria (Based on Former ADHS/DBHS) Level II Residential Treatment Center Services Continued Criteria
Therapeutic Foster Home	**Non-emergency:** At CFT but probably no longer than 30 days.	**Initial:** 30 days	Up until 6/30 of each year	N/A	N/A	ADHS Clinical Guidance Documents/PIPs
	Non-emergency: Before end of auth period.	**Continued:** Up until the next CFT or ISP review.		N/A	N/A	ADHS Clinical Guidance Documents/PIPs

Level	Clinical Decision Timeframe	Suggested Length of Auth	Max Length of Auth	BHP Can Auth But Only MD Denies	DOPA Form to NARBHA in 24 hrs	Authorization Criteria
All Outpatient, including Fee-For-Service	**Non-emergency:** at initial ISP or CFT or before end of auth period.	Up until the next CFT or ISP review.	Up until 6/30 of each year for fee-for-service	N/A	N/A	ADHS Clinical Guidance Documents/PIPs
Certain Medications (See Below)	**Emergency:** immediate **Non-emergency:** One business day	N/A	One year	N/A	N/A	See below.

The following medications are available through prior authorization:

NARBHA never denies a request to prior authorize a medication. Prescriber assurance that the medication is necessary is sufficient. Notice to NARBHA is required for certain prescriptions described below for the purpose of making changes in the Pharmacy Benefit System, which includes pharmacy edits on prior authorized medications so that the medication can be obtained by the member expeditiously. All prior authorization requests are processed within one business day and retrospectively reviewed by the NARBHA Medical Director for general trending.

- Brand-name medications on the NARBHA Medications Formulary when the generic form is available, per ADHS/DBHS. This includes medications with alternative formulations not available in the generic (Wellbutrin XL, Paxil CR, Prozac Weekly), Risperdal CONSTA and Ambien.
    - Authorization criteria: member-specific clinical reason such as allergies, noncompliance, prior response.
- Medication refills prior to 30 days when a 30-day supply was initially dispensed and/or when more than one-fourth of the days remain on the previously filled prescription.
- Prescriptions in excess of a 30-day supply or a 100-unit dose, with the exception of prescriptions for chronic illnesses, which are limited to a 100-day supply or 100-unit dose, whichever is more.
    - Authorization criteria: prescriber awareness and approval of excessive supply of medications to decrease risk of overdose, misuse, or diversion.
- Specific unit dose strengths of medications on formulary: Zyprexa 2.5 mg, Risperdal 0.25 mg and 0.5 mg, and Abilify 5 mg.
    - Authorization Criteria: Use of very small and cost-ineffective medication dosage units is reserved for children, the elderly, the medically ill, or initial or final titration schedules.

NARBHA's formulary includes all medications on the ADHS/DBHS medication list. Additionally, NARBHA has chosen to maintain a more comprehensive formulary of covered medications, as per the attached list.

NARBHA utilizes a pharmacy benefit manager, CaremarkPCS. All covered medications prescribed on or after an eligible member's enrollment date and on or before the member's closure date are paid through the NARBHA pharmacy benefit system.

NARBHA Service and Tribal Area Agency (SAA/TAA) medical practitioners may request changes to the formulary by submitting a request to the NARBHA Medical Director. All requests are reviewed by the NARBHA SAA/TAA Medical Practitioners Committee to make a recommendation to the NARBHA Plan and Design Committee, which ratifies the NARBHA Formulary. Additions or deletions are based on review of:

- Dosage forms, strengths, and cost of the medication requested;
- Average daily dosage;
- Indications for use (including pharmacological effects, therapeutic uses of the medication and target symptoms);
- Advantages of the medication (including any relevant research findings, if available);
- Adverse effects reported with the medication;
- Specific monitoring required.

Generic Name	**Brand Name**	**General Classification**
Alprazolam	Xanax	Anti-anxiety (benzodiazepine)
Amantadine	Symmetrel	Antiparkinsonian agent / Dopamine agonist/ antiviral
Amitriptyline	Elavil	Tricyclic antidepressant
Amobarbital	Amytal SOD	Barbiturate / Truth serum
Amoxapine	Asendin	Tricyclic antidepressant
Aripirazole (added 02/12/03)	Abilify[1]	Neuroleptic / anti-psychotic
Atomoxetine (added 02/12/03)	Straterra[2]	Non-stimulant agent / NE reuptake inhibitor
Benztropine	Cogentin	Antiparkinsonian agent
Bethanechol chloride	Urecholine	Cholinergic agent (Anticholinergic agent antidote)
Biperiden	Akineton	Anticholinergic agent / Antiparkinsonian agent
Bromocriptine	Ergoset	Dopamine agonist / Antiparkinsonian agent
Buprenorphine with and without naloxone (Added 05/ 04/04)	Suboxone[2], Subutex [2]	Partial agonist opiate with and without opioid antagonist
Bupropion	Wellbutrin, Wellbutrin SR, Wellbutrin XL[1]	Non-SSRI antidepressant
Buspirone	BuSpar	Non-benzo. anti-anxiety
Carbamazepine	Tegretol, Epitol, Carbitrol	Anticonvulsant / mood stabilizer
Chloral Hydrate	Noctec	Non-benzo. hypnotic for sleep
Chlordiazepoxide	Librium	Anti-anxiety (benzodiazepine)
Chlorpromazine	Thorazine	Conventional neuroleptic / antipsychotic
Citalopram	Celexa	SSRI Antidepressant
Clomipramine	Anafranil	Antidepressant / Anti-obsessional

Generic Name	Brand Name	General Classification
Clonazepam	Klonopin	Anti-anxiety / Anticonvulsant
Clonidine	Catapres	Hypotensive agent for impulsivity
Clorazepate	Tranxene	Anti-anxiety (benzodiazepine) / hypnotic for sleep
Clozapine	Clozaril	Atypical neuroleptic / Antipsychotic
Cyproheptadine hydrochoride	Periactin	Antihistamine / sedative / Antiparkinsonnian agent
Desipramine	Norpramin	Tricyclic antidepressant
Dextroamphetamine	Dexedrine, Dextrostat	Psycho-stimulant / amphetamine
Dextroamphetamine/Amphetamine	Adderal, Adderal XR	Psycho-stimulant / amphetamine
Diazepam	Valium	Anti-anxiety (benzodiazepine)
Diphenhydramine	Benadryl	Antihistamine / sedative / Antiparkinsonnian agent
Disulfiram	Antabuse	Alcohol ingestion deterrent
Divalproex / Divalproate	Depakote, Depakote ER	Anticonvulsant / mood stabilizer
Docusate Sodium	Colace	Stool softener
Doxepin	Sinequan / Adapin	Tricyclic antidepressant
Escitalopram Oxalate (11/01/02)	Lexapro[2]	SSRI antidepressant Isomer of citalopram
Fluoxetine	Prozac, Prozac Weekly[1]	SSRI antidepressant / anti-obsessional
Fluphenazine	Prolixin, Prolixin-D	Conventional neuroleptic / antipsychotic
Fluvoxamine Maleate	Luvox	SSRI Antidepressant / anti-obsessional
Folate (10/01/02)	Folic Acid[2]	Vitamin B
Guanfacine	Tenex	Hypotensive agent for impulsivity
Haloperidol	Haldol, Haldol-D	Conventional neuroleptic / antipsychotic
Hydroxyzine	Atarax / Vistaril	Antihistamine / sedative / Antiparkinsonnian agent
Imipramine	Tofranil	Tricyclic antidepressant
Lamotrigine	Lamictal[2]	Anticonvulsant / mood stabilizer
Levothyroxine	Levotabs, Synthroid, Levoxyl	Thyroid agent
Liothyronine	Cytomel	Thyroid agent
Lithium Carbonate / Citrate	Eskalith / Lithonate / Lithobid (GI coated)	Mood Stabilizer
Lorazepam	Ativan	Anti-anxiety (benzodiazepine)
Loxapine	Loxitane	Conventional neuroleptic / antipsychotic
Metamucil	Metamucil	Fiber laxative
Methadone	Methadone	Narcotic analgesic
Methamphetamine	Desoxyn	Psycho-stimulant

Generic Name	Brand Name	General Classification
Methylphenidate	Ritalin, Metadate, Metadate CD, Methylin, Concerta	Psycho-stimulant
Mirtazapine	Remeron	NonSSRI Antidepressant
Molindone	Moban	Conventional neuroleptic / antipsychotic
Multivitamins		Mixed vitamin supplement
Nadolol	Corgard	Betablocker for tremor and impulsivity
Naltrexone	Revia	Opiate antagonist for alcohol cravings
Nortriptyline	Pamelor	Tricyclic antidepressant
Olanzapine	Zyprexa[1] , Zyprexa IM added 5/04	Atypical neuroleptic / antipsychotic / mood stabilizer
Oxazepam	Serax	Anti-anxiety (benzodiazepine)
Oxycarbamazepine (added 11/1/01)	Trileptal[2]	Anticonvulsant / mood stabilizer
Paroxetine	Paxil, Paxil CR[1]	SSRI antidepressant
Perphenazine - Amitriptylline	Etrafon Forte[2]	Tricyclic antidepressant- neuroleptic combo med
Perphenazine	Trilafon	Conventional neuroleptic / antipsychotic
Phenelzine	Nardil	MAO inhibitor / antidepressant
Phenobarbital	Donnatal	Barbiturate / sedative
Pimozide	Orap	Typical neuroleptic / antipsychotic
Pindolol	Visken[2]	Betablocker / hypotensive agent / antidepressant augmentation
Propranolol	Inderal	Betablocker / anti-anxiety / impulsivity and tremor suppressant
Protriptyline	Vivactil	Tricyclic antidepressant
Pyridoxine	Vitamin B-6	Vitamin
Quetiapine	Seroquel	Atypical neuroleptic / antipsychotic
Risperidone	Risperdal[1], Risperdal CONSTA-[1] (added 12/16/03)	Atypical neuroleptic / antipsychotic. R-C: Long-acting injection
Sertraline	Zoloft	SSRI antidepressant
Temazepam	Restoril	Anti-anxiety (benzodiazepine) / hypnotic
Thiamine	Vitamin B[1]	Vitamin
Thioridazine	Mellaril	Conventional neuroleptic / antipsychotic
Thiothixene	Navane	Conventional neuroleptic / antipsychotic
Topiramate	Topamax[2]	Antiseizure / mood stabilizer
Tranylcypromine	Parnate	MAO inhibitor / antidepressant

Generic Name	Brand Name	General Classification
Trazodone	Desyrel	Non-SSRI antidepressant
Trifluoperazine	Stelazine	Conventional neuroleptic / antipsychotic
Trihexyphenidyl	Artane	Antiparkinsonnian agent
Valproate Sodium	Depakote	Anticonvulsant / mood stabilizer
Valproic Acid	Depakene	Anticonvulsant / mood stabilizer
Venlafaxine	Effexor, Effexor XR	Non-SSRI-type antidepressant
Verapamil	Calan SR[2]	Calcium channel blocker / hypotensive agent
Vitamin E	Vitamin E	Antioxidant vitamin
Zolpidem	Ambien[1]	Non-benzodiazepine hypnotic
Zyprasidone (added 4/9/01)	Geodon[2], Geodon IM[2]	Atypical neuroleptic

Footnotes

[1]Prior Authorization of some or all forms required
[2] Not on ADHS/DBHS Formulary

Prior Authorization Required:

- Wellbutrin XL- effective 10/1/03
- Zyprexa 2.5 mg- effective 10/1/03
- Prozac Weekly - effective 12/1/03
- Ambien- effective 12/1/03
- Paxil CR- effective 12/1/03
- Risperdal 0.25 mg- effective 12/1/03
- Risperdal 0.5 mg- effective 12/1/03
- Risperdal Consta- effective 12/16/03
- Abilify 5 mg-- effective 10/1/03
- All brand names when generic is available

Persons in Northern Arizona requiring behavioral health services can access the NARBHA system in a multitude of ways. Regardless of how they enter the behavioral health care system, or which provider is ultimately responsible for care, NARBHA's mission guarantees they will be treated in a manner that is respectful, culturally and linguistically competent, engages the member in the treatment plan, and honors the role of family as part of the assessment and service planning process. As the manager of the behavioral health care system in Northern Arizona for 37 years, NARBHA has worked diligently to maintain a process that allows people in need of care to access that care easily, timely, and appropriately.

Access to Care

To provide services that are community-based, geographically accessible, and culturally sensitive, NARBHA has divided its Geographic Service Area into nine local Services Area Agencies or Tribal Area Agencies (SAAs/TAAs). Behavioral health services are provided directly by the SAAs/TAAs or their sub-contracted providers. Persons can access the system in the following variety of ways.

- By directly contacting their local SAA/TAA
- By calling NARBHA, a Member Service Representative will assist the person in connecting with their local SAA/TAA
- By calling NARBHA's 24-Hour Response line for children removed from their home by Child Protective Services (CPS)
- Through the general crisis system which refers to the local SAA/TAA

Regardless of the method of initial contact, the local SAA/TAA must offer an appointment based on clinical need and according to the access standards for intake appointments. SAAs/TAAs are able to structure intake functions in the manner that best serves member's needs. Intake structures vary slightly given the provider's size and geographic area, however NARBHA requires all SAAs/TAAs to use the ADHS/DBHS comprehensive assessment. Qualified staff are identified specifically to perform assessments. Once the person goes through the intake and assessment process he/she is referred to as a "member" of the NARBHA behavioral health care system.

Assessments are available in community settings, such as hospitals, member's homes, jails, detention centers, or other locations, as to increase consumer and family convenience and the ease of access. As an example of the availability of community based assessments, NARBHA reports indicate that an average of 64% of all CPS 24-Hour Response assessments are done at off-site locations, which are typically the placement location which is most convenient to, and appropriate for, the children and their foster families or other caregivers.

During the initial assessment process "Next Steps" are addressed with the member and his/her supports. This is a temporary plan that addresses needs until the Service Plan is completed. The Clinical Liaison is responsible for assuring that each member receives these services, the first of which must be delivered no later than 23 days from the date of initial assessment. When special needs and preferences are identified during the assessment process (i.e.: member need for accommodation, member choice of provider related to cultural preferences, and other needs), it is the role of the Clinical Liaison to insure that these needs are met.

The Role of the Clinical Liaison

Clinical Liaisons are essential to the process of engagement when members are assessed and throughout the course of their services. Their role is to support the member and their family via unconditional commitment and to develop empathetic relationships in order to foster ongoing partnerships, respect, and equality. They develop collaborative relationships designed to engage and empower the member and family's unique strengths. Clinical Liaisons are Behavioral Health Professionals or Behavioral Health Technicians who receive the ADHS/DBHS prescribed training on their role and on the ADHS/DBHS Assessment process prior to their assuming this responsibility. In addition, NARBHA had added an additional required training in Cultural and Family Considerations as part of the Assessment/Clinical Liaison training.

NARBHA has developed a more specialized type of staff person referred to as a Family Involvement Specialist. These staff are trained as Clinical Liaisons and have also received additional training in the Child and Family Team process and in facilitation skills. This additional training aids the FIS in facilitating teams, which identify both non-categorical as well as categorical supports for the member and their family. FISs are utilized when members require teams made up of multiple agencies and tracked through the Human Resources Department database.

Family Involvement Specialists, along with all other Clinical Liaisons have been trained to understand the importance of assessments and service plans which are individualized, strengths-based, culturally appropriate, and clinically sound. They help to guide NARBHA's members and their families in ways that encourage the expectation that they are capable of positive change and growth, and can lead a life of value.

Human Resources Department Database

NARBHA maintains a Human Resources (HR) Department credentials database, which includes all SAA/TAA staff, their education, certification/licensure and expiration dates, date credentialed and trained to perform as a Clinical Liaison, and date credentialed and trained to perform assessments. Once a Clinical Liaison has completed their required training and they become credentialed, the following methods are utilized to insure an accurate list of all available Clinical Liaisons throughout the system.

- SAAs/TAAs issue a staff identification number for all Clinical Liaisons.
- This number is entered into the NARBHA Human Resources database and the NARBHA MIS data systems.
- SAAs/TAAs provide on-going updates to both the NARBHA Human Resources and MIS departments of newly credentialed Clinical Liaisons and assessment staff, including any updates of certifications and/or licenses.
- SAAs/TAAs notify NARBHA of any Clinical Liaison and assessment staff removed from active status based on staff turnover, loss of credentialing/privileging status due to expired licensure and/or certification, or reassignment of job responsibility within the agency.
- NARBHA maintains an up to date list of fully credentialed and privileged Clinical Liaisons and assessment staff.

Each SAA/TAA is responsible to provide updated staff information to the NARBHA HR Department on a continual basis (as staff changes occur) no later than the 17th of each month, to ensure related information is correctly reflected on the monthly Clinical Liaison Rosters and Assessment Reports.

Clinical Liaison Roster

NARBHA maintains a Clinical Liaison Roster that lists the Clinical Liaison that is assigned to each enrolled member. Standardized data structures and coding values have been implemented across NARBHA and all of its SAAs/TAAs which permits the providers and NARBHA to review the status of Clinical Liaison assignments at any time to assure coverage and assess caseloads and staffing needs. SAAs/TAAs submit Clinical Liaison data to NARBHA on all enrolled members. This member data is due to NARBHA within 14 days from date of intake and is rejected if the Clinical Liaison is not defined.

MIS Department Reports

The Management of Information Systems (MIS) Department at NARBHA creates and distributes two electronic Clinical Liaison/Assessment reports monthly and distributes them to the SAA/TAA Directors for their review. These reports compare enrollment and encounter data with the HR credentialing database to ensure that each member is assigned to a Clinical Liaison and appropriately credentialed staff are performing assessments. These reports are provided to SAA/TAA Directors to ensure that data is accurate. Corrective actions or financial sanctions may occur when problems are found.

The Clinical Liaison Report includes:

- Members without an assigned Clinical Liaison
- Members with a Clinical Liaison about whom NARBHA has no information in the HR credentialing database
- Members with a Clinical Liaison that is not identified as credentialed
- Members with a Clinical Liaison that is credentialed.
- Summary report of staff identified as Clinical Liaisons and the number of members.

The Clinical Assessment Report includes*:*

- Members who had an assessment billed (original or adjusted) in the reporting segment without a staff identification attached.
- Members who had an assessment billed under a staff identification number that is not in the HR credentialing database.
- Members who had an assessment billed under a staff number that is not associated with a person who is credentialed to perform Clinical Assessments.

- Members who had an assessment billed under a staff number that is associated with a person who is credentialed to perform Clinical Assessments.
- Summary report of staff credentialed to perform assessments, and the number of assessments performed each month.

Monitoring

NARBHA monitors assessments and the role played by Clinical Liaisons to ensure that assessments are performed by practitioners who are strength-based, appreciate the role of family, culturally sensitive, and clinically sound. Monitoring is through Case File Reviews (CFRs) that are performed by NARBHA's Quality Management staff. Reviews also include whether input from the member, family, and others, regarding the member's special needs, strengths, and preferences is included in their plan for services, and whether individuals who have an integral relationship with the members are included in the assessment and service planning process. These CFRs also monitor for appropriate signatures in order to assure that appropriately trained and credentialed staff have provided each service. NARBHA also monitors provider staff credentialing through site visits conducted by the NARBHA HR Department to review staff records. If deficiencies are identified through any monitoring activity, or through the standard electronic Clinical Liaison reports, NARBHA's Clinical Operations, Quality Management, and Human Resources Departments require that plans of correction be developed and implemented. These departments also provide technical assistance to NARBHA's providers and monitor progress and improvement.

In partnership with ADHS/DBHS, NARBHA has developed the children's behavioral health service system in Northern Arizona. An important part of that development has been to assist ADHS/DBHS with the implementation of the Jason K Settlement Agreement. One of NARBHA's major objectives is to emphasize the importance in supporting collaborative relationships between families and system partners in accordance with the Arizona Children's Vision and Principles in achieving meaningful positive outcomes for children and families. In collaboration with consumers, providers, and other stakeholders, NARBHA will identify and support implementation aimed at sustaining the Principles; identify system barriers and strategies for overcoming such barriers; and monitor and guide system reform efforts. It is essential, in order to understand the extent of change, to describe briefly some of the system characteristics that existed only a few years ago.

Arizona Children's Vision

Historically, children with serious emotional and behavioral disorders and their families were not given the services they needed. The mental health system itself was fragmented, services were institutionalized and rigid, and families were excluded from the treatment process. If families' needs were heard at all, they were often dismissed by mental health "experts" who "knew best." Families and their children were expected to respect and unquestioningly accept whatever was recommended. In the early 1980's, a national report challenged the mental health service systems across the country, asserting that most children with serious emotional disturbances were not receiving the care they needed (Knitzer, 1982). "The field of children's mental health was characterized by a lack of federal or state leadership, few community-based services, little or no advocacy on behalf of the youngsters with emotional disorders," Knitzer and Stroul (1996) reflected.

In 1988, Arizona enacted landmark legislation mandating the development and delivery of a comprehensive continuum of coordinated behavioral health care for children. Previous services had been provided by different state agencies according to individual mandates addressing specific sub-populations of children, but the legislative change required interdepartmental collaboration for a single system to address the behavioral health needs of all Arizona children. ADHS/DBHS was designated the lead agency for the development of this children's system.

Despite first-time access to federal Medicaid funding, the promise of the 1988 legislation had not been realized when, by the mid-1990's, a federal district court in Tucson, Arizona certified a plaintiff class action which would become known as *J.K. vs. Eden et al.* The process of discovery produced substantial evidence of merit to the plaintiffs' contention that the emerging system was ineffective and in need of significant change. Then Governor Jane Dee Hull ordered ADHS/DBHS and the state's Medicaid agency (the Arizona Health Care Cost Containment System, also known as AHCCCS) to enter into negotiations with the Plaintiff's attorneys. On June 26, 2001, the same federal district court accepted the resultant settlement agreement, ending a decade of adversarial process in favor of commitment to reform the system on behalf of "all persons under the age of twenty-one who are eligible for Title XIX behavioral health services in the State of Arizona, and have been identified as needing behavioral health services."

The centerpiece of the JK Settlement Agreement is The Arizona Children's Vision and Principles, which identifies meaningful behavioral health service outcomes for eligible children and their families. The Arizona Children's Vision is built on a set of 12 Principles, to which ADHS/DBHS and AHCCCS are both obligated and committed. The Arizona Children's Vision and Principles, in turn, are contractual obligations established by ADHS/DBHS upon NARBHA and its sub-contracted providers for services delivered to Title XIX and Title XXI children and families.

NARBHA has made significant progress with improving the system of behavioral health care for children and their families in Northern Arizona since the JK Settlement Agreement. Implementation of the Child and Family Team (CFT) practice and regional and state level collaborative groups have laid a strong foundation for an innovative system of care. To further implement the vision, NARBHA has modified its infrastructure to fully support the Arizona Children's Vision and Principles. NARBHA currently contracts with nine Service Area/Tribal Area Agencies (SAAs/TAAs) as well as other specialty providers to deliver services to all children. The strategies set forth in the annual JK Action Plans established by ADHS/DBHS will continue to guide NARBHA in its ongoing efforts to continue system development consistent with the Arizona Children's Vision and Principles. These efforts currently include the following and will be updated based on the ADHS/DBHS JK Annual Action Plan:

- Creating sustainable and trusting partnerships with families and other child-serving systems
- Developing, training, and implementing effective practice improvement protocols
- Continuing to train and coach system staff, partners, and families

- Developing effective venues for barrier identification, resolution, and feedback
- Changing to improve the quality management system
- Internalizing the understanding of system reform

Creating Sustainable and Trusting Partnerships with Families and Other Child-Serving Systems

NARBHA will continue to build partnerships that foster respect and active collaboration so that system-wide reform can occur. Over the past two years, in conjunction with ADHS/DBHS, NARBHA worked to increase its understanding of the mandates and requirements of the different child-serving agencies. NARBHA also focused on building collaborative efforts with stakeholders such as the Arizona Department of Economic Security/Child Protective Services (ADES/CPS) to foster development of Child and Family Teams (CFTs) at local and individual case levels across systems. NARBHA is in the process of engaging and partnering with families in system reform, requesting their participation in changes in the intake, assessment, service planning processes, and the strategic plan.

Partnerships with State Agencies

- NARBHA participates in the monthly Children's Executive Committee Meeting hosted by ADHS/DBHS to look at system issues from a statewide perspective.
- NARBHA hosts the Regional Children's Council of Northern Arizona, which is comprised of a wide range of stakeholder and family member representation that meet quarterly to discuss the system of care for the region.
- NARBHA meets every other month with ADES/CPS management to discuss on-going system improvement issues for the region. In addition to these meetings, CPS staff are regularly invited to participate in cross-training opportunities. Four CPS representatives completed the Trainer Training for CFT Facilitation in December 2003, and case managers from each local area participated in the community-based CFT trainings throughout the region.
- NARBHA meets every other month with the ADES/Division of Developmental Disabilities (ADES/DDD) management to discuss on-going system and case specific issues for cross-system children and has developed a Memorandum of Understanding to facilitate partnering. NARBHA and ADES/DDD have collaborated over the past year to host quarterly "Brown Bag Lunch Trainings" on issues faced by the developmentally disabled population, which includes children in the care and custody of ADES/DDD.

Input is gathered from these stakeholder meetings and councils and is dealt with in a collaborative manner with all parties involved. Information is also passed on for further review by the NARBHA Provider Performance Committee, which has a monthly standing agenda item to address issues specific to stakeholder input. This standing agenda item serves as a venue for the review of issues identified by the Regional Children's Council and its sub-committee.

NARBHA's Leadership Council, which meets weekly, serves as the central point for coordinating and ensuring that communication to and from NARBHA is dispersed in a timely, accurate, and consistent manner. Internal and external communication from behavioral health recipients, family members, and stakeholders is reviewed and monitored to gain necessary feedback for performance improvement and decision-making.

NARBHA will use this mechanism of committee structure to further strengthen our capacity to improve behavioral health for our consumers, improve our organizational infrastructure, focus our strategic planning and technical assistance, increase operational effectiveness, heighten public awareness, and mobilize community support for behavioral health.

<u>24-Hour Response for Child Protective Services Referrals</u>

In February 2004, NARBHA designed and implemented a comprehensive tracking and reporting database to improve 24-Hour Response for CPS. NARBHA centralized 24-Hour Response referrals from ADES/CPS through a dedicated 1-800 line at ProtoCall Services (a NARBHA contracted crisis service provider). ADES/CPS case managers call one number to request the response and the call is routed to the correct SAA to initiate the response.

Behavioral health providers then see each child in their placement within 24-hours of ADES/CPS referral. Through development of the tracking system, NARBHA is able to track a number of items including the age ranges of children referred, the location they were seen at, eligibility and enrollment status, timeliness of CFTs, average time to ADES/CPS referral from removal, average time from referral to face-to-face response, and response locations. NARBHA will continue to monitor and improve the process in collaboration with ADES/CPS.

Since implementation, the following data has been captured:

- Between August 15, 2003 and June 30, 2004, 250 children were seen through the 24-Hour Response process. This reflects 100% of the referrals made by CPS.
- During the first 6.5 months of 24-Hour Response, prior to implementing the centralized number and tracking, data shows 85 responses. In the 4.5 months following the tracking, data shows 165 responses. This reflects an average monthly increase of 35%, which primarily represents improved data tracking.

Data collected between February 15, 2004 and June 30, 2004 reflects the following:

- 55% of the responses were for children ages 0-6
- 94% of the children were seen in settings other than the clinic
- The average length of time from call to the first CFT was 11 days
- Only 73% of the children were Title XIX eligible

Therapeutic Foster Care (TFC)

Like other states, Arizona has seen an increasing need in recent years for foster care programs for children in the care and custody of the state that can serve children who require specialized clinical and supportive interventions. NARBHA partnered with an existing ADES/CPS District III foster care program in July 2003; providing Medicaid funding and substantial clinical and other supports, thereby rapidly expanding capacity in this new partnership. Now known as "Therapeutic Foster Care" (TFC), this evidence-based practice promises many children a chance to experience and practice the intimacy of family connections related to longer-term positive stability and permanency. This philosophy helps children to remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system. Without this practice these children might otherwise have been placed away from their communities, including out-of-state, and into more restrictive, institutional settings. Over the past few years, NARBHA has had very few children placed out-of-state, and is committed to providing a comprehensive array of behavioral health services to ensure that they receive the treatment and resources they need.

NARBHA, in collaboration with foster parents, provider agencies, and ADES/CPS developed a TFC handbook and participated in the state-level workgroup to develop the TFC Practice Improvement Protocol (PIP). NARBHA plans to distribute the ADHS/DBHS TFC PIP to the provider agencies and incorporate it into the handbook and practice once it is released. In addition to the handbook, TFC providers receive training, in-home family support, and therapeutic consultation services, as well as fair rates of compensation for provision of individualized care for children with serious emotional disturbances. NARBHA intends to further develop local TFC services and increase bed capacity through continued collaborative meetings in ADES/CPS Districts III and IV/Mohave County and continued contracting with ADES/CPS provider agencies for recruitment, retention, and development of the program. Through the ADES contract, the current providers also recruit, train, and support adoptive placement providers for ADES/CPS children through the adoption process and will be utilized as an on-going resource to help address the specialized support needs for adopted children and their families.

As of June 30, 2004, NARBHA had developed 13 homes with 38 beds. NARBHA plans to continue to recruit additional homes through contract provider agencies with a focus on retention in the ADES/CPS District III region and program development and expansion in Mohave County.

Co-location

In line with Governor Napolitano's plan for CPS Reform, one of the SAAs has co-located with CPS in Fredonia, and NARBHA intends to have behavioral health staff co-located on-site at several additional ADES/CPS offices. The intent of co-location initiative is to establish a more effective cross-system partnership to meet the unique needs of children and families involved with ADES/CPS. The intent is to establish a more effective cross-system partnership to meet the unique needs of children and families involved with ADES/CPS. This will be accomplished through the development of increased understanding between agencies, increased expertise for the population served, and facilitation of the provision of behavioral health services to the ADES/CPS population as measured by access, enrollments, timeliness, covered service provision, and decreases in utilization of higher levels of care and ADES/CPS-specific complaints, problem resolutions, and grievances. NARBHA also plans to issue a collaboration satisfaction survey as a baseline measure and at follow-up intervals to measure the changes in perceptions of collaboration between local behavioral health and ADES/CPS staff.

Special Foster Care Populations

Beyond increasing provider expertise on the needs of the general population of foster children, particular focus will be given over the next two years to meeting the needs of infants and young children in foster care and the needs of young adults transitioning into the adult system.

- Currently, one of the highest percentages of children currently entering ADES/CPS foster care in the NARBHA region is children in the 0-5 population. An increasing number of these are substance-exposed newborns. Through implementation of the 24-Hour Response program for ADES/CPS referrals, NARBHA is facilitating the responsiveness of the system of care to this population. NARBHA looks forward to increasing provider competence and expertise through training and technical assistance, once ADHS/DBHS releases the assessment information for the 0-5 population, to ensure that they receive the treatment they need.
- There is increased attention nationally on the specific needs of children age 16 years and older who face transition to adulthood and may age out of foster care. National data shows a high percentage of these children experience poor outcomes, including higher rates of criminal justice system involvement, underemployment, homelessness, and re-entry into the child welfare system as parents. NARBHA is committed to increasing the understanding at the CFT level of the need for a concerted multi-agency, multi-system effort that focuses on the transition, support, and specialized planning needs for this population. NARBHA looks forward to incorporating the Transition to Adult Practice Improvement Protocol into future trainings once it is released from ADHS/DBHS.

Increase the Role of Families in System Reform

In July 2004, NARBHA developed, out of Community Development and Wellness services, a Family Leadership Committee comprised of family members and other constituents, Office for Children with Special Health Care Needs (OCSHCN) community alliances, National Alliance for the Mentally Ill (NAMI), Mentally Ill Kids in Distress (MIKID), and Advocating, Success, Knowledge, and Independence (ASKAN). These groups have been instrumental in helping NARBHA define family involvement and understand expected levels of participation and how to enhance those levels of participation when recruiting behavioral health recipients, family members, and stakeholders for peer and family support positions.

Family leadership targets for the coming fiscal year include:

- Increased family leadership on at least four NARBHA committees;
- Increase family leadership in program/training designs relative to the Arizona Children's Vision and Principles;
- Increase family leadership in the design, implementation, and training of both the Adult and Family Team and the CFT processes; and
- Build infrastructure for the provision of support and rehabilitation services.

NARBHA is also working with the definition of family involvement/leadership as a continuum of personal growth. There are various ways in which this can be achieved by looking at areas in which it can occur:

- Parenting: Family involvement at the most basic, most important level; caring for their child, establishing a routine, modeling problem solving, attending the child's activities.
- Participating in Family Support Activities: Taking advantage of and creating opportunities for self growth; reading a newspaper, requesting and using parent to parent match, going to a support group, attending workshop or training.
- Partnership with Agencies and Organizations: Involvement can include providing input to agencies on program or policy decisions.
- Planning Family Support Activities: Moving beyond personal needs to organize and plan activities for other families; facilitating support group or meeting, contributing to newsletter, being a parent mentor, provide training for other parents and professionals.
- Policymaking and Community Development: Partnering with professionals in working in the community to enhance opportunities for children with special needs. Write, call or meet with legislators regarding policies impacting families, working on systems change such as designing a model for service coordination.

Develop, Train, and Implement Effective Practice Improvement Protocols

ADHS/DBHS Practice Improvement Protocols (PIPs) play an important role in system reform. To date, considerable progress has been made in modifying existing protocols to ensure their alignment with the Arizona Children's Vision and Principles. New protocols have also been developed for CFTs and for the use of psychotropic medication in children and adolescents. Significantly, the CFT protocol articulates the intention to serve *all children* through CFTs. Indeed,

NARBHA's goal is to serve 100% of children receiving behavioral health services through CFTs by October of 2006. NARBHA utilizes the CFT PIP in all facilitator trainings and plans to incorporate the upcoming CFT Technical Assistance Document (TAD) as a cornerstone of the curriculum.

NARBHA offers regular training and technical assistance to the SAAs/TAAs. Prior to utilizing any out-of-state trainers, NARBHA prepares them with all relevant PIP, TAD, and Arizona Children's Vision and Principle information to include and reference in their trainings.

NARBHA will be reviewing the new ADHS/DBHS Therapeutic Foster Care PIP to incorporate in the NARBHA TFC handbook. NARBHA also expects to roll out trainings on the new Transition to Adult PIP. A variety of venues are utilized to train providers on new information including, the NARBHA Adult/Child Committee, the Regional Children's Council of Northern Arizona, Districts III and IV/Mohave County Therapeutic Foster Care Advisory Committees, and ADES/CPS and DDD Every Other Month Meetings.

Continue to Train and Coach System Staff, Partners, and Families

In meeting the requirements of the JK Settlement Agreement, NARBHA, in conjunction with highly skilled local and national trainers and coaches, has developed and implemented numerous training opportunities for providers, staff, families, and stakeholders related to the Arizona Children's Vision and Principles and the CFT Process. Material that is covered includes family centered and strengths-based approaches to treatment, facilitation of CFTmeetings, how to identify and use wraparound supports, cultural competency, and engaging parents as partners.

<u>Training for the Continued Development of Child and Family Teams</u>

In the three years since the JK Settlement Agreement, NARBHA's CFT practice innovations have laid the foundation for an innovative system of care. NARBHA has focused on establishing the knowledge base for the CFT model within the provider agencies. Children's services staff at all the provider agencies have received training in the basic fundamentals of CFT practice in line with national best-practice models. NARBHA will continue to be open and responsive to feedback from ADHS/DBHS, behavioral health recipients, family members, and community stakeholders in local implementation.

In 2001, NARBHA began working with national expert, John VanDenBerg, to introduce wraparound philosophy and practice into the network. In November 2003, NARBHA contracted with the Child Welfare Policy and Practice Group to conduct a four-day Trainer Training on CFT facilitation. Family Involvement Specialists (FIS) from each SAA and their supervisors, along with representatives from NARBHA and CPS completed this intensive four-day training. At that time, NARBHA also contracted with Child and Family Support Services out of Maricopa County to provide six months of intensive training, coaching, and technical assistance on-site to each SAA. They introduced the basic principles and practices of the CFT model to all child-serving staff and provided intensive coaching and technical assistance to identified FISs.

In addition, NARBHA contracted with national consultant and wraparound expert, Jon Eagle, to work with the White Mountain Apache Tribal provider and community. Over the next year, NARBHA will be working with consultants to provide training to the Hopi Tribal provider and community.

NARBHA will build upon these past CFT training efforts in the following areas:

- Beginning in March 2004, ADES/CPS in District III requested NARBHA participation in the County Attorney/Attorney General directive to establish a "Justice Center" in Colorado City, a remote, rural community along the Utah/Arizona border. NARBHA and SAA staff have been participating monthly in the community development meetings where behavioral health recipients, families, and stakeholders have provided input in the development of a dual county, dual state, multi-agency service plan. Part of the behavioral health agreement was to offer CFT Facilitator Training to community members and the multi-agency staff that will be serving shared-system children in the area.
- Trainings are also being provided for the TAAs and Tribal Social Services. In FY 2003-2004 Jon Eagle worked with Apache Behavioral Health Services and other local Tribal social services and community providers. Training is planned with Hopi Guidance Center and Hopi Social Services for Fall 2004 on CFT Facilitation.
- NARBHA is working on the development of a sustainable curriculum to maintain and increase capacity of trained facilitators and increase knowledge for all child-serving behavioral health staff throughout the provider agencies on CFT practice.

- NARBHA will continue to train Clinical Liaisons to be more effective in implementing the system's new strength-based assessment process for children and families. The curriculum is geared toward helping Clinical Liaisons begin the Strengths and Culture Discovery process – an important underpinning of CFT practice – during their assessments.
- Facilitators for complex families--One facilitator can effectively facilitate up to 15 CFTs for complex, multi-agency involved families. Beginning in July 2004, NARBHA started the process for on-going determination of how many trained facilitators are needed in the network in order to meet the needs of active, enrolled multi-system Title XIX and Title XXI children and families. Each provider agency will provide training in line with standards established by NARBHA to train facilitators.
- A children's staff supervisor at each provider agency has received facilitator-level training and was actively involved in the on-site coaching provided over the past six months by Child and Family Support Services. NARBHA will continue to offer training and technical assistance to supervisory staff at provider agencies and develop guidelines to help supervisors support fidelity to the model.
- Every child in NARBHA's network has an assigned clinical liaison. Clinical liaisons will be trained in the basic skills of CFT facilitation as the primary framework for the provision of behavioral health services.
- All new staff members who work with children and families will be trained on the Arizona Children's Vision and Principles as the foundation for interactions with children and families receiving behavioral health services, and will have an understanding of the basic foundation of CFT practice.
- NARBHA is interested in developing more video-based and multi-media trainings and recently added a cultural competency video into the assessment training. NARBHA is also pursuing use of the E-Learning program, a computer-based training program specifically designed for behavioral health organizations, for on-going training opportunities.

In addition to CFT trainings, many collaborative opportunities have been provided by NARBHA to improve clinical staff, the community, families, and other stakeholders' knowledge about the new service delivery model. NARBHA maintains an Excel spreadsheet which outlines the current regional House Bill 2003 and Federal Block Grant training plan for children's services. The plan is continuously revised and updated based on provider needs, identified gaps, and input from ADHS/DBHS. Additional trainings, outlined on this plan include:

- NARBHA developed training materials on CPS and the 24-Hour Response process including a flowchart for training behavioral health providers and stakeholders to improve cross-system understanding, establish clear guidelines, and create and maintain a focus on the purpose and child-driven need of the model. In addition to trainings, NARBHA has created a 24-Hour Response overview and Arizona Children's Vision and Principles document that is being mailed to all foster homes in the region in Fall 2004 in order to enhance caregiver understanding of the process.
- In April 2004, NARBHA hosted two one-day trainings entitled "Responding to Foster Children and Foster Families". Dr. Richard Delaney, a national expert in child welfare, presented to approximately 140 representatives from NARBHA's provider network and a wide-range of key community stakeholders. The intent of the training was to improve provider and team member understanding of the unique needs of foster children.
- NARBHA offered scholarships for SAA staff to attend the Annual Arizona Child Abuse Prevention Conference. The focus was on foster care with Governor Napolitano and ADES Director David Berns, both giving keynote addresses. NARBHA also offered scholarships for foster parents and SAA staff to attend the Infant-Toddler Mental Health Institute in September. The first day of the training was specific to young children in foster care.
- Within this fiscal year, NARBHA plans to purchase the "Shared-Parenting" curriculum from the Child Welfare Institute in order to explore opportunities for development of enhanced Therapeutic Foster Care in the region. In this program foster parents are trained to work directly with birth families.
- NARBHA is hosting a two day conference on Autism in October 2004 based on requests from parents and stakeholders.
- In addition to the joint-training activities and collaborative efforts already described, NARBHA has offered to conduct training on behavioral health services in the local ADES/CPS New Employee Orientations as requested.

NARBHA is working to ensure that its provider network possess sufficient capacity and skills to serve the needs of children and their families. Network development efforts are on-going to establish contracts with community service agencies that offer support and rehabilitation services. These services include but are not limited to respite, living skills, personal assistance, health promotion, and family support. NARBHA has also initiated the process for identifying provider staff with experience and expertise within identified specialty areas. In 2001, ADHS/DBHS identified certain

specialty areas, which would be most appropriate in helping ADES/CPS meet the unique needs of children who have been removed from their homes. NARBHA continues to track these specialty areas as follows:

- Attachment and Bonding
- Adoption
- Sexual Abuse
- Sexual Offenders
- Eating Disorder
- Post Traumatic Stress Disorder (PTSD)

As a result of NARBHA's collaborative effort with ADES/DDD, NARBHA has chosen to track SAA staff who are skilled in working with developmentally disabled population.

NARBHA is working with Touchstone Behavioral Health to provide Multi-Systemic Therapy and Functional Family Therapy within the network for substance abusing, dependent, and chronic juvenile offenders as an evidence-based practice. Additionally, Apache Behavioral Health Services received a recent grant to develop multi-systemic therapy within their service area.

Develop Effective Venues for Barrier Identification, Resolution, and Feedback

Identifying and resolving barriers is essential to realizing the Arizona Children's Vision and Principles. NARBHA has developed a process with input from ADHS/DBHS, providers, and other stakeholders to collect and analyze system information about successes, challenges, and barriers. One of NARBHA's committees, the Regional Children's Council of Northern Arizona, which is comprised of a wide range of stakeholders, meets quarterly to discuss the children's system of care for the region. The Council recently approved the development of the Barrier Resolution Subcommittee, which will meet monthly to review and resolve identified systems barriers elevated from CFTs, parent groups, and other community, state agency stakeholder meetings, and complaint, complaint resolution and grievance and appeal trending. The sub-committee will have a core membership including ADES/CPS, ADES/DDD, NARBHA, education, and parent/community group representation. Barriers and resolutions will be tracked in a database and be reported quarterly to the Council and to the NARBHA Provider Performance Committee. The sub-committee will maintain a focus on and commitment to the Arizona Children's Vision and Principles as the foundation for barrier resolution.

Change to Improve the Quality Management System

The Quality Management System plays a critical role in evaluating how well the behavioral health system is performing according to the Arizona Children's Vision and Principles. The Quality Management System helps identify areas for improvement and facilitates targeted improvement efforts. Currently, the Quality Management System includes a variety of approaches to assessing the behavioral health system's performance for children's related issues. These include:

- Independent Case Review: NARBHA reviews the results of the ADHS/DBHS Independent Case Review in NARBHA's Provider Performance Committee (PPC) on an annual basis for child specific performance indicators. Areas of non-compliance are forwarded to the Provider Improvement Committee (PIC) in order for plans of improvement to be developed. The approved plans are implemented and tracked throughout the year by the PIC. The status of the plans is reviewed by the PPC and the NARBHA Leadership Council to assist in removing any barriers that may arise. In addition, NARBHA conducts its own Case File Review (CFR) during the month of October (results reported to the PPC in January). This affords NARBHA the opportunity to gain insight into child specific performance levels at "mid-term".

- Monitoring key indicators: NARBHA monitors the list of ADHS key indicators (now referred to as performance measures) through the PPC. PPC members determine if any improvement opportunities exist by comparing NARBHA's performance with that of the other RBHAs. If any are identified, they are passed down to the PIC so that improvement plans may be developed. NARBHA also builds in processes to assess, plan, implement, and evaluate the quality of care provided, and to demonstrate compliance with program standards according to the ADHS/DBHS Policies and Procedures Manual. NARBHA takes an active role in monitoring and tracking of quality improvement findings on a local and state-wide basis and will take such actions as determined necessary to improve the quality of care provided to behavioral health recipients.

- Utilization data review: A process for the development of NARBHA's Annual Provider Network Development and Management Plan is a comprehensive review of quantitative and qualitative data that identifies strengths and gaps in NARBHA's provider network. In addition to analyzing quantitative data, such as utilization, penetration rates, network inventories, etc, NARBHA obtains qualitative data to evaluate that services are being provided in a manner that is consistent with the Arizona Children's Vision and Principles from communications with stakeholders such as members and families; provider agencies; and state agencies such as the ADHS/DBHS, ADES/CPS, ADES/DDD, the court system; and advocacy organizations. Recent examples of this stakeholder input and partnering include the expansion of Therapeutic Foster Home placements for children and the upcoming development of a Level II Residential Agency/Group Home for individuals who are dually diagnosed with behavioral health issues and developmental disabilities.

- CFT trained facilitators: Beginning July 1, 2004, NARBHA began reporting quarterly to ADHS/DBHS on the number of CFTs lead by trained facilitators. NARBHA has developed an electronic tracking system. This process will track Strength and Cultural Discoveries, team meetings facilitated by credentialed FISs, and team meetings facilitated by other staff such as therapists and clinical liaisons. In addition to training staff as facilitators, part of the intensive on-site training and coaching plan includes training all children's services staff on CFT philosophy and practice.
  - For the period November 1, 2003 through June 30, 2004, NARBHA had 26 staff credentialed as Family Involvement Specialists. Eleven of these staff were functioning full-time in this capacity and 16 were trained as trainers.
  - It is estimated the number of CFTs led by people other than credentialed FIS is at least two times higher. The new tracking system will allow NARBHA to more accurately view capacity.

- CFT fidelity: Over the next two years, NARBHA will begin to develop a focus on increasing fidelity to clinical practice protocols through monitoring and analyzing CFT data through provider reports, chart reviews, guided interviews, and through additional training and technical assistance. NARBHA will utilize performance and fidelity data to develop actions to be taken in areas of training, structure, and service provision. NARBHA will balance the needs of maintaining fidelity with being responsive to the unique needs of each family and community.

- Program design: All new programs go through the NARBHA Plan and Design Committee for development. This allows for multi-departmental planning and more holistic program design. The 24-Hour Response process is an example of children's program development through this committee. The combination of structuring for a clinically sound, best-practice programming, while building in data, research, performance, and monitoring measures allowed for the development of the comprehensive tracking measures describe previously. Part of the design built in quarterly program monitoring through the Provider Performance Committee as well.

- Complaint review: NARBHA tracks and trends all complaints, complaint resolutions, grievances, and appeals using a spreadsheet tracking log. The information is aggregated by provider, type of issue, nature of complaint, etc. This information is reviewed by the PPC on a quarterly basis. If improvement opportunities are identified, the PIC is requested to develop an improvement plan. Trends from this data will also be reviewed by the Barrier Resolution Committee for review and resolution.

- Financial review: NARBHA reviews how contract providers are spending monies and has additionally set-aside monies to ensure certain services such as Title XIX Therapeutic Foster Care and Respite are adequately funded.

- Consumer satisfaction survey: NARBHA participates in the ADHS/DBHS Consumer Satisfaction Survey process. NARBHA distributes the results of the survey to all of its SAA providers who participate in the process. This information is used to improve care within the system. SAAs report to NARBHA improvement activities associated with the issues highlighted in the survey results.

- Administrative review: NARBHA participates in the ADHS/DBHS Administrative Review process on an annual basis. The improvement opportunities identified as a result of the review are incorporated into the performance improvement process.

- Measure structure, practice, and outcomes: NARBHA assisted ADHS/DBHS and its sub-contractor (HSAG) in identifying the case review sample and scheduling interviews for the CFT review process.

Internalize the Understanding of System Reform

Over the next year, NARBHA will continue to build on these training, coordination, and communication efforts and will work to ensure that written policies and guidelines align with the Arizona Children's Vision and Principles. Accordingly, NARBHA will create and/or revise policies, and educate on ADHS/DBHS Clinical Guidance Documents. NARBHA plans to bring regional awareness to Family Involvement and Leadership through the dissemination of the Family Involvement Brochure (English version was completed and distributed, Spanish version in process of printing); and the Arizona Vision and 12 Principles bookmark (English/Spanish). NARBHA is also developing posters in English and Spanish on the Arizona Vision and 12 Principles to post at each SAA/TAA as an activity to assist with visibility and integration.

Training will also be held for providers to relate practice to the Children's Vision and the JK Annual Action Plan Strategies. Any national trainer is oriented by NARBHA staff to Arizona-focused language and processes including the Arizona Children's Vision and Principles, relevant Clinical Guidance Documents and Assessment information prior to coming onsite to further integrate and support current practice and system change.

As the backbone of the NARBHA provider network, SAAs/TAAs will also play a role in internalizing system reform during the next year. Agencies will be expected to inform new employees of their job roles and functions as they relate to system reform and to identify operational practices, which will guide providers through the implementation of the Arizona Children's Principles within each agency.

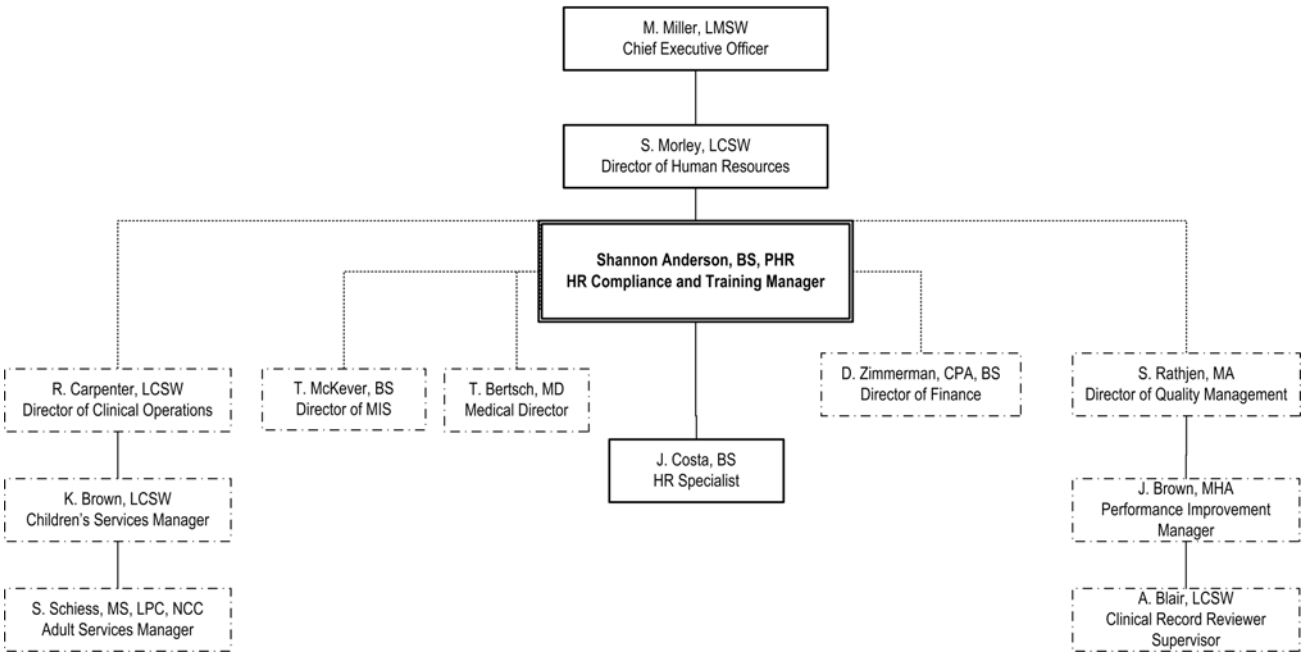
Collaborative meetings will continue at the state and local level to **c**ommunicate on reform activities between NARBHA, ADHS/DBHS, consumers, and providers. These meetings will focus on communicating expectations and key responsibilities and will benefit NARBHA by providing feedback on the effectiveness of current efforts.

Organization of Training Function

The training function at NARBHA coordinates training activities for internal NARBHA staff and for its provider network, which consists of Service Area Agencies and Tribal Area Agencies (SAAs/TAAs) and other providers. SAAs/TAAs serve as the backbone of the provider network and offer a comprehensive array of services in nine sub-regions in Northern Arizona. NARBHA's role is to: identify training needs, using input from a variety of sources; provide leadership and technical assistance in developing or procuring training resources; and monitor training participation and outcomes.

The Human Resource Compliance and Training Manager reports to the Director of Human Resources and is responsible for oversight of all training related functions. Many other experienced NARBHA staff support and provide resources and input into the coordination and development of training. For example, the Director of Clinical Operations is very involved with the development and implementation of clinical trainings, as are other clinical, quality, finance and management information system staff. An HR Specialist position provides support to training activities and reports directly to the HR Compliance and Training Manager. This design works well because it is a collaborative effort inclusive of key departments, but with a central point of coordination and responsibility through the HR Compliance and Training Manager. Since NARBHA's Human Resources Department interacts regularly with all departments, structuring the training function within Human Resources assists with coordination with all other functions. Also, since training documentation is such an important element for assuring compliance with contractual, accreditation and credentialing requirements, NARBHA's Human Resources Department monitors staff credentials and associated personnel records for necessary training components. By having NARBHA's Human Resource Director oversee training and personnel functions, the design is well-coordinated and efficient.

Northern Arizona Regional Behavioral Health Authority
Training Organization Chart



NARBHA believes training responsibility for on-going provider employee needs should reside at the provider level for sustainability and applicability at the line staff and clinical supervisor level. For example, employee orientation and training for ongoing clinical functions should occur at the provider agency level. Therefore, NARBHA has structured training so that routine provider employee training functions occur at the provider organization level, with direction and leadership provided by NARBHA. Each SAA/TAA has a position that is designated as a liaison and coordinator for training communications and activities. These provider positions interface regularly with the NARBHA Human Resource Compliance and Training Manager to disseminate training information throughout the network. NARBHA communicates training requirements regarding ADHS/DBHS contract requirements and initiatives in regularly scheduled meetings with SAAs/TAAs, such as those with executive directors, financial officers, clinical managers and management information system staff. NARBHA's description of SAA/TAA training responsibilities and requirements is also communicated through the ADHS/DBHS/NARBHA Provider Manual. In addition, NARBHA provides a monthly training calendar, flyers and brochures, and e-mail communications to the training coordinators at each agency. NARBHA's website also includes a training calendar.

Needs Identification

NARBHA's Strategic Plan for FY 2002 included a goal regarding strengthening the process of identifying and prioritizing training needs. From the strategic plan workgroup, a series of changes took place, one of which was the development of a training Prioritization Matrix. NARBHA's Prioritization Matrix includes criterion such as source of request (i.e., NARBHA, Provider, or AHCCCS/DBHS), supporting/monitoring data (i.e. data from the annual ADHS/DBHS Independent Case Review), risk, due date, whether the training is part of an improvement activity, and implementation requirements. This Prioritization Matrix is very helpful in prioritizing needs, setting appropriate timelines and ensuring resources are available for training.

An example of how this process has been successful in identifying training needs for NARBHA was in the identification of the need for additional training on Child and Family Teams. Through monitoring of SAAs/TAAs on the implementation of the Child and Family Team (CFT) initiative, it was apparent that more training was necessary. By applying the Prioritization Matrix, this was identified as a critical training need. NARBHA responded and held five CFT trainings in various locations across the region. SAA/TAA staff and key stakeholders such as the Department of Economic Security/Child Protective Services, Juvenile Probation, and families were invited to attend these sessions at no cost. The focus of the training was to establish foundations for building CFTs and to provide training to potential CFT facilitators.

Annual Training Plan

Once training needs are identified through the needs identification process, NARBHA develops an annual Training and Staff Development Plan (the Training Plan) which outlines goals and initiatives foreseeable in the coming year for both NARBHA staff and its provider network. The Training Plan describes implementation for each identified training area. For example, the Training Plan for March 2004 – 2005 includes cultural competency, service plan documentation, supervisory skills, confidentiality of protected health information, best practices, and data analysis/reporting. Last year's plan included two ADHS/DBHS initiatives, Dialectical Behavioral Therapy, and Clinical Liaison/Assessment training, which were held during the year.

Targeted Training Efforts

NARBHA Internal Training

Training of NARBHA staff begins with new employee orientation. NARBHA holds a monthly, two-day orientation for new hires. Training is emphasized at NARBHA to build staff competency in their position and to keep abreast of best practices in the various functional areas. Identification of training goals is a component of annual performance evaluations for NARBHA staff. Training goals are then tracked annually for each NARBHA employee.

The Human Resource Compliance and Training Manager assesses NARBHA training needs through the review of training goals stated on performance evaluations, the annual employee survey and exit interview data. When a trend is discovered, NARBHA utilizes either in-house expertise or contracts with a vendor to develop training. Several years ago, a trend in performance evaluations indicated a need to improve staff competency in data analysis and interpreting data reports. Because of the need, a series of staff trainings was developed. Other training needs identified through performance evaluations have included training for supervisors and computer skills.

Provider Training

NARBHA requires SAAs/TAAs to provide new employee orientation for their staff. Included are all of the topics outlined in the ADHS/DBHS Provider Policy Manual and the ADHS/DBHS Contract. Some of the clinical topics include Behavioral Health Record Documentation, Ethics, Grievance and Appeals, Best Practices in the Delivery of Care, Confidentiality, Covered Services, Coordination of Care, the Arizona Children's Vision and Principles and others. NARBHA provides a sample curriculum to the SAAs/TAAs and technical assistance when requested.

Providers who are joining the NARBHA network receive one-on-one attention from NARBHA's Finance and Management Information System staff. These NARBHA employees work closely with prospective new providers during the application and contracting process. NARBHA staff participate in numerous meetings with the prospective subcontracted provider to clarify subcontract requirements, the claims submission process, and how NARBHA's provider network operates. Based on the volume of services and the administrative needs of the provider, on-site training and technical assistance is arranged as needed.

For support services, such as Community Service Agencies (CSA), NARBHA implemented a series of trainings in 2002 and 2003 to create awareness in communities across Northern Arizona of the expansion in NARBHA's provider network for these services. NARBHA provided State-required training in four parts of the Geographic Service Area, inviting known potential community agencies to attend in order to assist them in meeting the requirement that CSAs obtain specific training before applying to the State for CSA Certification. A specialized training module is available at NARBHA for organizations applying to become Community Service Agencies.

Clinical Liaison Training

NARBHA also develops, funds or coordinates multiple provider training events throughout the year as a part of implementation of the Training Plan. For example, NARBHA held five training sessions in FY 2003-2004 throughout Northern Arizona to reach over 200 provider staff eligible to perform assessments and/or act as Clinical Liaisons. To sustain this training effort and more efficiently reach new hires at the providers, this training is now delegated to the SAAs/TAAs and monitored by NARBHA.

Agencies are also required to report to NARBHA which employees have been trained and function as Clinical Liaisons/ Assessors. During HR site visits, personnel files are reviewed for the required Clinical Liaison/Assessment training documentation. NARBHA has also developed a report that compares the staff credentialed as Clinical Liaisons/Assessors and/or eligible to perform assessments against staff who report services under these codes. Any outliers are reported back to the SAA/TAA to correct the discrepancy or require the performance of the function to cease until the staff person is appropriately trained.

Collaborative Training

NARBHA also uses training as a collaboration opportunity, partnering with state and regional organizations to deliver training to providers, consumers, family members and other key stakeholders. Examples of collaborative training activities are:

- To build skills for the care of the developmentally disabled population, NARBHA has collaborated with Department of Economic Security (DES) and Northern Arizona University to deliver the quarterly "Brown Bag Lunch Series". Each quarter, staff from the SAAs/TAAs, DES and other community agencies attend a two hour training on varying topics related to the delivery of care to this population. These trainings have a high number of attendees across the region, because they are held over the NARBHA videoconferencing system, which reduces travel time for participants.

- NARBHA and the Department of Economic Services/Rehabilitation Service Administration (DES/RSA) Vocational Rehabilitation Services have been working collaboratively for over thirty-five years. An annual training conference is held in the Spring and sponsored by NARBHA and DES/RSA. This training conference takes place over a two day period and is designed to cover a variety of topics relative to the challenges of service delivery in rural areas, creative job development and obstacles that may impede consumer success in placement. For the past two years, the first day has been focused on consumer participation. This has become one of the most successful and compelling portions of the training and the feedback is overwhelmingly positive.

Training Methods

Training in the NARBHA region is delivered through a variety of methods. Because the region has many rural communities with widely dispersed providers, videoconferencing is utilized to reach the necessary audience and deliver the information in a cost effective manner by reducing trainer and staff travel time. NARBHA currently has 12 videoconferencing sites, available for training, throughout its provider network. In addition to training within the NARBHA region, numerous state-wide training events are also available via videoconferencing. These are routinely available to NARBHA and its providers. NARBHA staff and medical practitioners at the SAAs also participate in weekly Psychiatric Grand Rounds offered by the University of Arizona School of Medicine for continuing medical education credits. Each participating video conferencing training site has a designated coordinator who facilitates and monitors participation, and ensures sign-in sheets, post-tests and evaluation forms are completed before certificates of attendance are distributed.

Another method frequently utilized by NARBHA is 'train the trainer' courses. With this method, NARBHA develops the training material and holds one training. Each SAA/TAA is required to designate one or two staff persons, who will be responsible for the continuation of training at their own agency. NARBHA frequently supplements 'train the trainer' curriculum with videotapes that include certain components. A recent example is a video on Service Planning: Cultural and Family Considerations developed by NARBHA. SAAs/TAAs are required to utilize this module in conjunction with the ADHS/DBHS Part I Assessment and Clinical Liaison training module. NARBHA developed this video as part of an improvement plan because cultural assessment of members was identified as an issue by the ADHS/DBHS Independent Case File Review process. NARBHA also created facilitator guidelines, training handouts, and a post-test for use by the SAA/TAA trainers.

NARBHA holds site based trainings at SAAs/TAAs. When appropriate, NARBHA holds training at strategic locations throughout the region that make attendance more convenient for agencies located in rural areas. Recent examples include the CFT training and Grievance and Appeals training that occurred in 2003-2004 at each SAA/TAA. However, with videoconferencing availability throughout the region, the need for on-site trainings has been reduced.

To further increase capacity for delivering accessible, cost-effective training, NARBHA and the majority of the Service Area Agencies are implementing Essential Learning (E-Learning). E-Learning is a software program that contains a comprehensive library of topics concerning behavioral health, including material developed according to ADHS/DBHS standards and JCAHO accreditation requirements, such as dual diagnosis, guidelines for documentation, and corporate compliance. This tool creates improved access because provider staff will be able to access the training material via personal computers. The software tracks the required training by staff person, the due date to complete trainings, the percentage of the module the person has completed, and the pre/post test scores. The software will also track when a person is due to have completed all required annual training, and sends e-mail reminders to staff and supervisors. This program will greatly enhance NARBHA's capability to produce outcome-based evidence of knowledge and skills developed in trainings.

In order to streamline training registration, NARBHA is redesigning its website to include a training web page that will have an on-line registration mechanism. The website web page which includes NARBHA's training calendar will include hyperlinks to the applicable handouts for each scheduled training. This feature will ensure those who participate over videoconferencing have the necessary handouts.

Monitoring

For training required by ADHS/DBHS contract, NARBHA provider subcontracts and the ADHS/DBHS/NARBHA Provider Manual, NARBHA monitors SAA/TAA training activities annually to ensure appropriate development, facilitation and documentation of training. NARBHA monitors training activities through its Training Monitoring Tool that is used during the annual site visits conducted by the Human Resource Department. Monitoring occurs to review that orientation is received within stated time-frames and that staff receive annual training on the DBHS required topics. The monitoring also covers Office of Behavioral Health Licensure requirements that clinical staff receive 48 hours of training in the first year, and 24 hours of training every year following. During FY 2003-2004 monitoring, all SAAs agencies passed NARBHA's compliance threshold of 90% with the exception of one agency. This agency was required to develop a corrective action plan to implement the trainings that were missing from their orientation process.

NARBHA also monitors to ensure that training materials have been developed by staff who are qualified to do so, and these materials are reviewed as a part of the visit. Corrective action is required if non-compliance is identified.

Outcomes

Training outcomes are assessed by NARBHA at the individual employee level and at the provider level. NARBHA utilizes several methods to assess individual staff competency. Recently, a comparison of pre and post-test results was measured against requirements for a passing score for the Assessment/Clinical Liaison training. For example, Behavioral Health Technicians (BHTs) must complete Part I and Part II of the ADHS/DBHS Assessment/Clinical Liaison trainings with a post-test score of 80% or better. NARBHA set a standard that a staff person has two opportunities to retake the test within 30 days of receiving the training. Failure to pass after three tries requires the employee to retake the entire course. Thus far, all BHTs have passed the training without having to retake the course.

The E-Learning program which is being implemented this year by NARBHA and the SAAs will also assist in tracking staff competency through the program's on-line pre and post test scoring and tracking. The software will notify the training coordinator and supervisor of persons that did not receive a passing score, and the compliance threshold for specific trainings. NARBHA and the SAAs will be able to track and report on training effectiveness much more efficiently.

When training changes are made based on reported data, NARBHA reviews that same data source after implementing training to see if the training was effective in the improvement process. A recent example is that in 2003 NARBHA scored a 37% for compliance with Grievance and Appeals notices. After NARBHA provided extensive training to providers on this topic, the Administrative Review score improved to 82% for 2004.

Financial Resources

NARBHA estimates that at least $750,000 per year will be dedicated to staff and provider training across the entire region. This estimate was developed based on a combination of staff resources dedicated to training, administrative time devoted to training coordination, and budgets for specific training initiatives and for attendance at off-site and external conferences and training events. It is important to note that the estimate excludes training associated with individual coaching of staff, clinical supervision of staff and on the job training. Trainer preparation time for material development, and costs for food, lodging and transportation for training within the region are also excluded from the estimate. Also excluded is the time expended by experts within NARBHA, such as Clinical Operations, Quality Management or other departments who develop training plans or content.

The estimate of annual training expenses is detailed in the table below and explained in the following paragraphs.

Staff resources dedicated to training	$ 245,000
Administrative time for training coordination	250,000
External conferences and training	180,000
Specific training initiatives	75,000
Total	750,000

As described above, a large portion of training occurs at the provider network level for orientation and internal staff training. The majority of the training that occurs is training to build clinical competency and to roll out new initiatives to clinical staff. There are eight designated training liaisons and/or training coordinators at SAAs/TAAs that devote a significant portion of their time to training. Across the network and at NARBHA there are 5.5 designated training FTE's (full time equivalents), which equates to approximately $245,000 in training related salary costs. There is also the administrative time associated with training coordination, and those costs are estimated at $250,000 annually based on an average of 845 hours per month across the region. An additional $180,000 is budgeted in total for the region for staff to attend conferences and for agencies to sponsor conferences. Thus, there is approximately $675,000 in routine training costs across the NARBHA and its SAAs/TAAs on an on-going basis.

In addition to the routine training costs, there are training resources dedicated to specific training initiatives that can vary in amount and content area from year to year. Recently, the training associated with the development of the Children's System of Care, has consumed significant training resources. NARBHA has tracked, in detail, the dollars spent and consultants utilized to increase the network capacity of Child and Family Team (CFT) Trainers and Facilitators, to enhance community development efforts, to provide stipends for parents to encourage involvement in the CFT trainings, to provide training to the Tribal Area Agencies on the Wraparound Services philosophy, for training region-wide on

Professional Boundaries, and to develop curriculum to continue training after the contracted consultants are no longer utilized. Over two fiscal years (02/03 and 03/04) NARBHA expended approximately $157,000 for training related to the development of CFT capacity and expertise. An additional $100,000 is budgeted for the current fiscal year for development of a Therapeutic Foster Care Handbook for agencies and parents, brochures and bookmarks for Family Involvement and for the Arizona Children's Principles which will be available in both Spanish and English, training for services for infants age 0-5, training on autism, and training directed toward enhancements to the foster family system.

Based on routine training costs of $675,000 and resources dedicated to new initiatives of $75,000, NARBHA estimates conservatively that $750,000 will be devoted to training each year across its own organization and its SAAs/TAAs.

NARBHA performed well on the most recent ADHS/DBHS Independent Chart Review in the area of outreach and follow-up after discharge from inpatient and Residential Treatment Center (RTC), exceeding the standard of 80% in all areas. In the NARBHA system, outreach/follow-up occurred within specified times in 89.5% of adult inpatient cases, 100% of children inpatient cases, and 100% of RTC cases for both adults and children. NARBHA achieved this level of performance based on a combination of working collaboratively with its providers, utilization management activities during Level 1 stays, and monitoring past performance to target improvement efforts.

Each member in NARBHA's region is assigned to the Service Area Agency/Tribal Area Agency (SAA/TAA) where they reside. NARBHA contracts with its SAAs on a sub-capitation basis. This assignment of members, when coupled with the alignment of financial incentives, encourages contracted providers to exercise the appropriate behavior towards persons discharged from Level I facilities that is appropriate and timely follow-up after discharge. This timely follow-up allows the SAAs/TAAs to meet the needs of their members within their communities, thus limiting the use of higher cost crisis and inpatient services.

For members in care at the time of admission or non-enrolled persons who present in a crisis, SAA/TAA Clinical Liaisons or crisis staff have the primary responsibility for securing and coordinating necessary services during and after the Level I services. Adults needing inpatient services are referred to their designated NARBHA sub-acute facility. Youth needing inpatient services are referred to the closest, available fee-for-service inpatient facility.

NARBHA and its providers also use community peer support programs and/or consumer-operated Recovery Centers (NAZCARE) to provide a network, support, and connection for members both before and after Level I admissions. A Recovery Center representative, with member consent, visits members while the member is at the inpatient facility to begin the process of support, engagement/re-engagement, and assisting the member to develop their recovery goals through a Wellness Recovery Action Plan (WRAP). The Recovery Center also has a "Warm Line" that allows members to keep connected to a support network when they return to the community.

NARBHA's inpatient sub-acute facilities have established discharge follow-up clinics where members are scheduled based on clinical need with a medical practitioner usually within seven days, but not more than 30 days post-discharge. The NARBHA pharmacy benefit system allows for seamless prescribing by any inpatient medical prescriber so that eligible members may receive sufficient medication supplies to last until an outpatient prescriber sees the member. NARBHA's four Level 1 sub-acute facilities have established coordination of care processes with the referring SAAs/TAAs to ensure that discharge planning is effective and coordinated. For example, Community Counseling Centers (CCC) sub-acute facility is responsible for acute care of adult members from the Little Colorado Behavioral Health Center (LCBHC) region. Every Thursday, CCC sub-acute medical staff in Show Low and LCBHC outpatient medical and clinical staff (located in Flagstaff, St. Johns, and Springerville) review all LCBHC members who are inpatient via a standing telemedicine link to discuss discharge planning.

NARBHA has defined utilization management performance standards as of July 1, 2004 for SAA/TAA follow-up post-discharge as: Minimum Performance: 50% within 7 days; 55% within 30 days; Goal: 60% in 7 days; 65% within 30 days; Benchmark: 72% within 7 days; 80% within 30 days. NARBHA reviews SAA/TAA performance quarterly on this measure. Regular training at the NARBHA SAA/TAA Medical Practitioners Committee occurs on best practices related to this standard. On recommendation from the Provider Performance Committee, corrective actions are taken as necessary.

Also, NARBHA members who receive inpatient services are monitored through the NARBHA Utilization Management record review every quarter. The sample size is selected at 95% +/- confidence level for all admissions. There are eight questions related to the appropriateness of the treatment plan and criteria for discharge. There are two questions related to discharge planning and to continuing care to meet the member's assessed needs at discharge.

Additionally NARBHA's annual Case File Review monitors that the types and intensity of services are provided based upon the needs identified in the individual's assessment and treatment recommendations. It also measures whether the Clinical Liaison is actively involved in the oversight of the member's treatment and that there is outreach for missed appointments, service refusal, and medication refusal. An additional question measures whether services are provided in a timeframe responsive to the urgency of the member's need. Corrective actions and sanctions are routinely done when necessary.

NARBHA has been engaged in strategically planning and implementing a culturally competent regional prevention system since 1995. Most preventative interventions minimize risk and enhance protective factors to create conditions, opportunities, and experiences that help promote healthy, self-sufficient people.

The NARBHA system of care provides high quality, culturally competent, safe, and effective prevention services as part of its full continuum of care. Prevention strategies are focused on the prevention of substance abuse, child abuse, and suicide. The behavioral health wellness and cultural competency standards that are in place are designed to help specialized community prevention providers expand their range of culturally competent services.

NARBHA's overarching goals for the promotion of prevention are to:

- Reduce the incidence and prevalence of behavioral health disorders
- Reduce demand and need for more expensive and intensive treatment services
- Improve functioning related to specific skill-building strategies
- Heighten personal community awareness of risk factors for behavioral health dysfunction
- Effectively utilize current resources to address the needs of the communities

Prevention Goals and Objectives

Specialized community prevention providers are required to develop localized goals and objectives in accordance with NARBHA's overarching goals to provide sound prevention approaches built on culturally competent prevention program models. Developing an understanding and appreciation of and responsiveness to cultural differences is critical for reaching appropriate prevention program goals. A comprehensive program should employ a multi-faceted approach that seeks to reduce the most significant risk factors faced by the target group. It also should increase protective factors to offset the risks that cannot be changed by the program's intervention.

For example, a NARBHA prevention provider designed a program for adults ages 55 years or older who are experiencing depression, loneliness, and grief. Strategies to address the needs of this target group include: one-on-one peer support; home visits that focus on support and education; peer-led workshops; and links to community and social services. Taken together, these strategies could mitigate the impact of stressors that could result in depression, suicide, or substance abuse.

Prevention programs that incorporate research-based strategies maximize the likelihood of success. For example, the developmental model, which is a research-based prevention strategy, provides insights for selecting strategies that will help youth make healthy choices when faced with multiple, complex, and sometimes conflicting pressures of society. One of NARBHA's providers uses the research-based Search Institute Forty Developmental Assets Model to provide a longitudinal, comprehensive school-based program that follows a diverse group of selected at-risk first and second graders through sixth grade. The program is designed to develop over time a minimum of 18 specific internal and external assets to help children make healthy decisions about risky behaviors such as alcohol use and bullying, thus increasing school attachment, developing community bonding, and reducing early initiation of problem behavior such as delinquency.

To continue to improve its prevention system, NARBHA has established the following goals for the coming year.

- Develop a plan to focus and evaluate long-term efficacy of secondary prevention activities.
- Improve the quality of suicide prevention efforts in Northern Arizona.
- Market and increase access to prevention programs to target a more universal population.
- Increase awareness of child abuse prevention programs outside of the Regional Behavioral Health Authority (RBHA) system.
- Improve methods that show consistent reduction in risk and protective factors related to substance abuse in Northern Arizona.
- Increase efforts toward evaluating the effect of community alliances/coalitions on reducing substance abuse.

Every three years, NARBHA issues a Request for Proposals (RFP) requesting competitive sealed proposals from potential community providers to address the prevention needs of Northern Arizona. Proposals are selected based on the following criteria: are able to demonstrate that strategies are based on science or research models; offer services that are age-specific, developmentally appropriate, and culturally sensitive; offer ongoing, as opposed to brief, intervention; show evidence of collaboration with other community agencies; are based on a current needs assessment; and include an outcome evaluation. Contracted community prevention providers are required to adopt NARBHA's philosophy and

implement requirements from the ADHS/DBHS Covered Services Guide as part of their subcontracts.

Assessment and Planning

NARBHA uses a variety of data collection techniques to assess regional needs such as substance abuse among youth, family functioning, suicide among adolescents and elderly, literacy, and school drop-out rates in Northern Arizona. These techniques include social indicator data collection, population surveys, census data, demographic data, and key informant/expert discussions. The first two techniques, social indicator data collection and population surveys, are the most widely used. Focus groups, community forums, nominal group process, advisory groups, and task forces, collectively labeled "key informant/expert discussions," are traditionally used to supplement survey and social indicator data by providing much more detailed and descriptive interpretations of a situation. The quality of the data received through these techniques relies primarily on the ability to include participants truly representative of the target communities and the ability of the planners to avoid biasing the responses through interviewing methods.

Assessments (conducted in collaboration with other organizations, such as the Arizona Criminal Justice Commission, coalitions, United Way, Arizona Department of Economic Security Division of Developmental Disabilities, and Arizona Department of Education) address specific priority areas determined by evaluation of the data, including current literature in relation to risk and protective factors, prevalence rates, and/or social indicator data. Assessments conducted by other sources, such as other health care organizations, public health departments, and school systems, are also utilized. All data are analyzed based on best practice models and the ADHS/DBHS Prevention Framework for Behavioral Health to determine the priority needs/areas for Northern Arizona. These needs/areas are then addressed through NARBHA's prevention RFP process or through addendums to current prevention or Service Area Agency (SAA) contracts.

Assessment data, along with input from families, state agencies, advocacy groups, community stakeholders, and providers, is used for development of a Behavioral Health Promotion and Wellness Plan that describes NARBHA's philosophy and guidelines for focusing prevention for the next year. The NARBHA Leadership Council reviews and approves the Behavioral Health Promotion and Wellness Plan annually. Leadership Council is chaired by the Chief Executive Officer and is comprised of NARBHA senior management.

Prevention providers also are monitored as a part of the quality management process. If a specialized community prevention provider is out of compliance with any NARBHA or ADHS/DBHS Prevention Program Standards, the Provider Performance Committee reviews and provides feedback necessary for performance improvement activities.

Prevention Services

Specialized community prevention providers such as Yavapai Regional Medical Center, Big Brothers/Big Sisters of Northeastern Arizona, Yavapai Big Brothers/Big Sisters, Parenting Arizona (formerly known as Parents Anonymous), West Yavapai Guidance Center, The Guidance Center, and Prescott Unified School District are required to engage in culturally appropriate and diverse activities that promote and enhance the health and well-being of their local communities, based on specific needs and priority areas as identified by a needs assessment. These activities include outreach (in-home visits on and off the reservation; community-based programming; basing programs where the clients are, e.g., schools, churches, community centers), screening/early identification (depression, suicidal ideation, child abuse and neglect, school dropout), and referral to treatment for substantial behavioral health issues (substance abuse). Referrals to existing community-based resources (e.g., Alcoholics Anonymous, Department of Economic Security, etc.) and collaboration among community providers are also encouraged as a means to efficiently and effectively promote the health and wellness of residents of NARBHA's geographic service area.

Specialized community prevention contractors provide or participate in various prevention activities within as well as outside of their contracted prevention/early intervention models. These activities are based upon each contractor's assessment of specific needs and priority areas. Such activities might include: participation in the annual Depression Screening Day, Mental Health Month, National Recovery/Wellness Month, or various wellness fairs; inclusion of health promotion and wellness information in a member newsletter; free educational seminars and workshops; and other types of outreach, screening/early identification, and referral activities.

Every resident of Northern Arizona is eligible for culturally appropriate and diversified NARBHA prevention services. Effective prevention programs based on best-practice models are modified to meet the unique needs of the populations to be served. Potential populations and subgroups who benefit from prevention services include youth in juvenile detention

facilities, isolated Native American reservation communities, individuals presenting at community health clinics, isolated elderly individuals at risk for depression, people for whom English is a second language, and out of school youth, just to name a few.

Evaluation

No single, standardized evaluation format is appropriate for evaluating each and every prevention initiative. Prevention programs are required to conduct process and outcome evaluations throughout the year. Impact evaluation is optional but encouraged.

- Process Evaluation: Process evaluation is done on a quarterly basis and is descriptive in nature. It provides information on the people served by the program and documents the program's activities, materials, and staffing. This also helps track information on milestones reached throughout the year, monitors scheduling and quality, tracks program costs, and creates a descriptive base for program replication. The quarterly reports enable comparisons between the program plan and its actual implementation, and provide opportunities to adjust and refine the program as needed.
- Outcome Evaluation: Outcome evaluation is completed annually and focuses on the extent to which the program's short-term goals and objectives have been met. Short-term outcomes usually are in regard to attitudes, knowledge, and behavior. Goals may be affective in nature, such as satisfaction with the program; cognitive in nature, such as gains in knowledge or skills; or behavior-based, such as reduction in unexcused absences from work or school.
- Impact Evaluation: Impact evaluation is optional for specialized community prevention providers due to the expense associated with this type of evaluation. The purpose of this evaluation is to determine long-range changes in behavior, and changes in individual and community health and wellness. The overall purpose of this type of evaluation is to determine whether the program had the desired effect on behavior, such as a decrease in the number of substantiated child abuse incidences.

An internal written evaluation plan for each contracted community prevention program is prepared annually and updated to provide the necessary information to adjust and refine the program as needed. The information is then incorporated into NARBHA's Behavioral Health Promotion and Wellness Plan. Basic elements of the evaluation include:

- Statement of the goals and objectives to be evaluated
- Description of how the goals and objectives are linked to the target population and identified needs, including risk and resiliency factors
- Summary of the planned implementation process
- Specification of measures and indicators for the process, outcome, and impact portions of the evaluation
- Data source
- Data collection procedures
- Data analysis and reporting processes

NARBHA prepares a report for ADHS/DBHS annually, evaluating the outcomes of prevention programs and formatted according to the Prevention Framework for Behavioral Health and the Arizona Prevention Resource Inventory.

All Programs
NARBHA completed a detailed analysis for each category of service and each funding source in the areas of unique utilizers, annual units per unique utilizer, and average cost per service, and summarized the results on Attachment E. It is important to note that, while the assumptions described below were incorporated into the detailed analysis, the resulting percentage changes and trends shown on Attachment E may be minimal because of offsetting effects of changes to the respective assumptions.

Title XIX Child
NARBHA will increase support services, including case management and family support, to reflect capacity for serving 100% of children through Child and Family Teams (CFT) by October 2006. The inpatient and residential categories reflect a reduced length of stay due to increases in support services.

Title XIX Child CMDP
In conjunction with input from Department of Economic Security/Child Protective Services (DES/CPS) regarding their priority needs and based upon a comparison of utilization by CMDP children and Title XIX and XXI children, NARBHA found that CMDP children have a significantly higher utilization of residential treatment centers, psychiatric hospitals, Level II facilities and therapeutic foster care placements. NARBHA will increase support services to reflect serving 100% of children through child and family teams by October 2006, increases in case management, family support, therapeutic foster care, and crisis intervention services/assessment (24-hour response to CPS), while gradually decreasing residential and inpatient services. NARBHA will also increase the number of utilizers and units per utilizer for behavioral health day programs due to the addition of multi-systemic therapy (treatment services).

Title XIX SMI and Non-Title XIX SMI
Development of the recovery model and therapeutic foster homes in Northern Arizona for persons with Serious Mental Illness (SMI) will result in an increase in support and rehabilitation services and decreases in crisis intervention, inpatient and residential services and the behavioral health day treatment programs. Increase in peer support services, under the recovery model, will increase member use of the consumer-operated recovery center and support services.

Title XIX GMH/SA and Non-Title XIX SA
Development of rural transitional detox facilities in Northern Arizona will result in a significant increase in unique utilizers on an annual basis. Decreases in crisis intervention, inpatient and residential services will result from increases in the following areas: rehabilitation services for supported employment and living skills training; peer support; housing for substance abuse pregnant and parenting women; case management; personal assistance; and family support. The development of the substance abuse behavioral health day treatment programs in the NARBHA region will result in a decrease in Level I inpatient substance abuse and Level II residential services. Implementation of Dialectical Behavior Therapy will result in decreased inpatient and crisis intervention services. For Title XIX GMH/SA, an average of 45% of members will see a medical prescriber. For non-Title XIX, substance abuse medications are not a covered benefit but are available for persons who experience changes in Title XIX eligibility

1 **Attachment E: Estimated Allocation of Revenues**

Contract Year 2006 Offeror Name: NARBHA

Category of Service	Title XIX				Non-Title XIX	
	Child*	Child CMDP	SMI	GMH/SA	SMI	SA
501 Treatment Services	23.65	12.89	7.60	26.83	8.67	42.08
502 Rehabilitation Services	5.42	1.78	6.86	1.41	1.87	2.04
503 Medical Services	4.51	2.72	5.32	5.98	9.49	1.27
504 Support Services	33.19	29.87	33.16	25.09	26.77	15.22
505 Crisis Intervention Services	0.35	0.17	0.60	0.97	0.73	5.90
506 Inpatient Services	9.73	20.78	9.47	6.88	11.96	15.40
507 Residential Services	2.47	12.91	4.34	4.49	3.35	7.11
508 Behavioral Health Day Programs	0.42	0.17	0.50	0.22	0.43	0.00
510 Medications	10.26	8.71	22.15	18.13	26.73	0.98
513 Subtotal	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
Administration	7.50	7.50	7.50	7.50	7.50	7.50
Profit **	2.50	2.50	2.50	2.50	2.50	2.50
Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Note: Total should equal 100%

*** Does not Include children that are enrolled in CMDP.**

**** As a non-profit organization, this amount will be used to continue to meet the capitalization, performance bond and other financial viability requirements of the ADHS/DBHS contract.**

Contract Year 2007 Offeror Name: NARBHA

Category of Service	Title XIX				Non-Title XIX	
	Child*	Child CMDP	SMI	GMH/SA	SMI	SA
501 Treatment Services	21.07	13.50	8.14	29.73	9.27	42.29
502 Rehabilitation Services	4.83	1.87	7.30	1.68	2.07	2.17
503 Medical Services	4.99	2.89	5.03	5.44	9.17	2.01
504 Support Services	37.61	35.93	35.97	26.53	27.88	17.74
505 Crisis Intervention Services	0.35	0.18	0.54	0.87	0.68	5.70
506 Inpatient Services	8.17	16.25	7.68	5.20	11.27	13.12
507 Residential Services	2.28	9.99	4.05	3.71	3.35	6.11
508 Behavioral Health Day Programs	0.41	0.27	0.35	0.26	0.40	0.03
510 Medications	10.29	9.12	20.94	16.58	25.91	0.83
513 Subtotal	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
Administration	7.50	7.50	7.50	7.50	7.50	7.50
Profit **	2.50	2.50	2.50	2.50	2.50	2.50
Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Note: Total should equal 100%

*** Does not Include children that are enrolled in CMDP.**

**** As a non-profit organization, this amount will be used to continue to meet the capitalization, performance bond and other financial viability requirements of the ADHS/DBHS contract.**

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Contract Year 2008 Offeror Name: NARBHA

Category of Service		Title XIX				Non-Title XIX	
		Child*	Child CMDP	SMI	GMH/SA	SMI	SA
501	Treatment Services	19.73	14.18	7.25	32.12	9.71	41.91
502	Rehabilitation Services	4.52	1.96	7.40	1.76	2.28	2.39
503	Medical Services	5.30	3.04	5.29	5.93	9.10	2.01
504	Support Services	38.99	37.92	37.69	23.91	28.53	20.18
505	Crisis Intervention Services	0.32	0.19	0.55	0.76	0.61	5.58
506	Inpatient Services	7.06	13.38	5.96	4.23	10.97	11.56
507	Residential Services	2.01	9.33	3.62	3.11	3.21	5.36
508	Behavioral Health Day Programs	0.34	0.35	0.23	0.25	0.38	0.06
510	Medications	11.73	9.65	22.01	17.93	25.21	0.95
513	Subtotal	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Administration	7.50	7.50	7.50	7.50	7.50	7.50
	Profit **	2.50	2.50	2.50	2.50	2.50	2.50
	Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Note: Total should equal 100%

*** Does not Include children that are enrolled in CMDP.**

**** As a non-profit organization, this amount will be used to continue to meet the capitalization, performance bond and other financial viability requirements of the ADHS/DBHS contract.**